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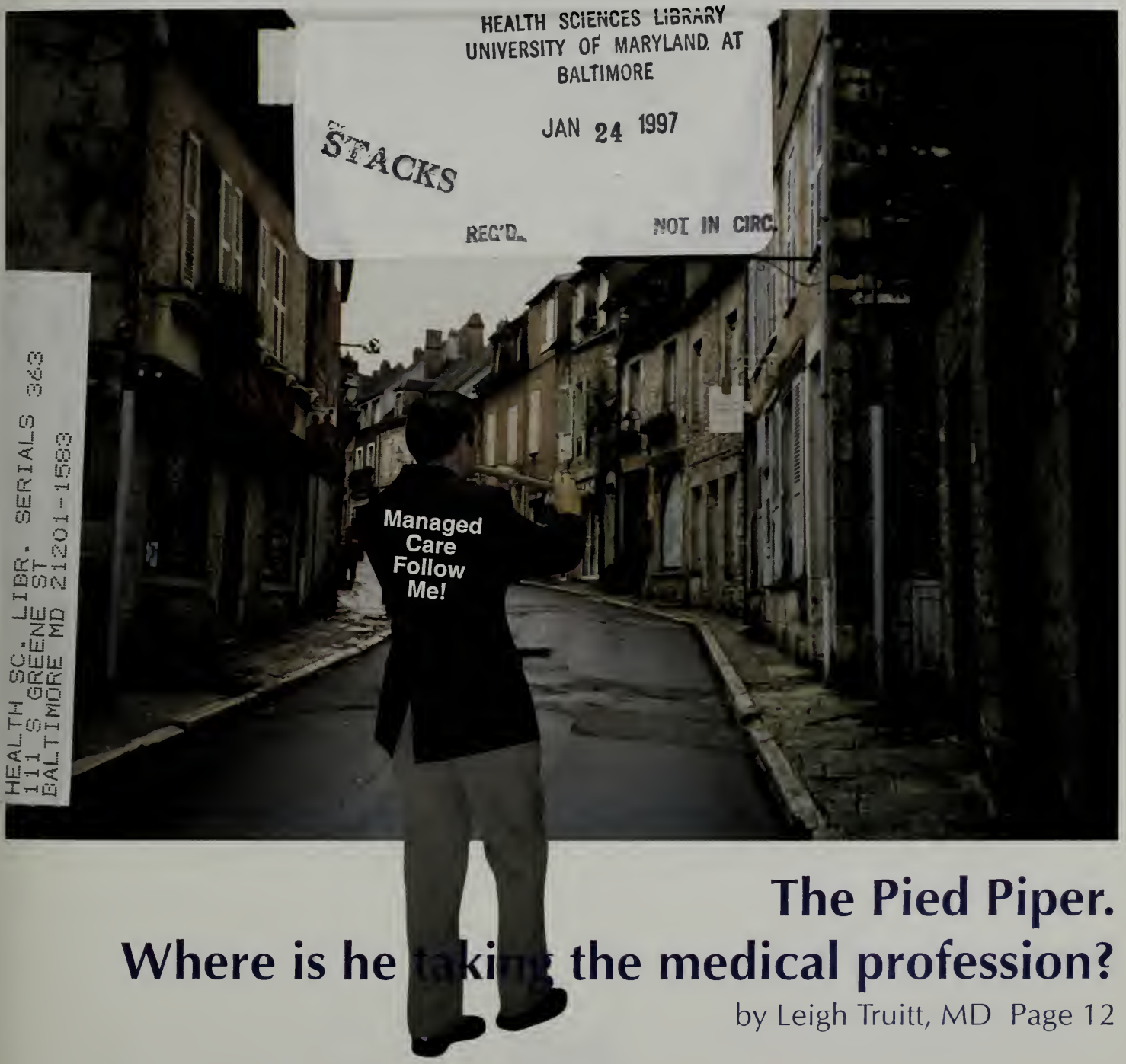
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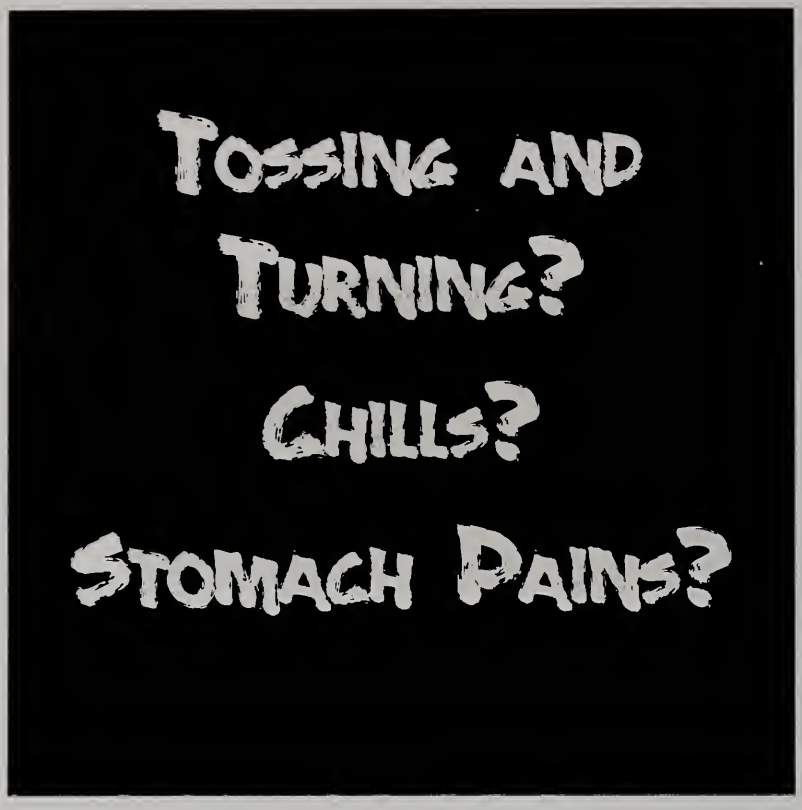


The Pied Piper. Where is he taking the medical profession?

by Leigh Truitt, MD Page 12

This Issue:

Torturing data in the Information Age ..... *M. Ray Painter, MD, FACS*
Continuity of care: CMS and CHMOA team up ..... page 16
Recommendations for transition of care ..... page 17
Can organized medicine unify? ..... page 18



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COLORADO MEDICINE

January, 1997 Volume 94, Number 1



Cover Story

Where is the Pied Piper of Health Care taking medical practice? Some say it's not all good; others say it's not all bad. Dr. Leigh Truitt says..... (page 12)

Departments

5 President's Letter
9 Executive Director's Update
11 The Lobby
24 Archives
28 Member Services
34 Medical News
36 Classified Advertising
38 Ruminations

In This Issue...

5 **The Information Technology Revolution, CMS and you:** Business and health care have a lot in common when it comes to data.
M. Ray Painter, MD
President, CMS

12 **Where is Managed Care taking the Medical Profession?** Are they calling the tune? Will health care professionals pay the piper?
Leigh Truitt, MD

14 **Recognition:** A gift to W. Gerald Rainer, MD.

16 **Cooperation:** new efforts between CMS and CHMOA produces accord on Continuity of Care.

18 **Change:** The new federation can unify and organize medicine
Joel M. Karlin, MD,
AMA Alternate Delegate

24 **Gentleman Jim:** An inspiring look at the life of James J. Waring, MD
John L. Lightburn, MD,
CMS Historian

27 **C.R.O.P. Report**: Results of the feasability study
Peter B. Milstein

29 **Physician billing:** it will be affected by changes in Medicare coding.

30 **1997 list of state and U.S. legislators**

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M. Ray Painter, MD
President, 19961997

The Information Technology Revolution, CMS and you

What does data, informatics, informational technology, outcomes, clinical guidelines, utilization, electronic medical records, intranets, the Internet and the World Wide Web have in common? Directly or indirectly all of the above will be part of your future.

The information revolution is at the heart of the health care revolution. The ability to collect, organize and interpret large volumes of data has allowed non-physicians, such as bankers, stock analysts, business managers, venture capitalists, etc., to gain insight into the fiscal aspects of health care. By applying their financial savvy, they have undeniably had a profound impact on the business of health care.

Expanded computer power and applications understanding are key to our changing communications systems. First there were faxes and computer modems, and now the Internet and intranets are reshaping things. How will our uses of these modalities change the practice of medicine? What is next?

Fortunately or unfortunately, depending on our views of change, the information revolution and its impact on the practice of medicine is in its infancy. The changes that will occur in the future will dwarf the technological leaps that have occurred in the past. The real questions plaguing most of us center on how these changes will affect our practices. What do we need to do to prepare ourselves for those changes? Moreover, what can CMS do to assist us?

First and foremost, many of the changes will be for the better. They will make our lives easier, improve our efficiency, decrease the hassle factor, increase productivity, and enhance quality of care. Currently we are practicing during the most difficult of times. Despite that fact, the future looks bright. (Well, maybe not the immediate future!)

Just imagine the following scenario. Arriving at the office our first cup of coffee is ready. We turn on our computers, and all of the information about the day's patients is available. As we see patients, we touch the screen or use the "mouse" to move the arrow to click on the selected box to enter findings, diagnoses and treatments. We won't have to be expert typists. This easy process will initiate a series functions. Documentation is complete, coding is automatic, referral letters are sent, patient education information is provided, and prescriptions are electronically sent to the pharmacy. Drugs are checked for allergy interaction and duplication of function. Managed care formularies are consulted. Suggestions for changes are automatic, as well as a requests for authorization for prescribed drugs. Treatments are checked for conformity to existing guidelines. Patient history is checked and any additional treatment or diagnostic considerations are brought to our attention. Verification, precertification and authorization are handled via computer. Billing tracking and payment are automatic from computer to computer. Outcomes and utilization information is continually updated and immediately available. Finally, all medical literature is organized and available,

"If you torture data long enough it will confess."

(Continued on following page)

President's Letter cont.

including specific answers to difficult questions.

Life is good. The hassle factor is gone. Now we can spend time with our patients.

Impossible? I don't think so. Think of your car. During her keynote speech at the recent Annual Meeting Leanne Kaiser Carlson noted that, "the new Toyota has more computers than the first space shuttle. And you don't even notice they are there". Your car is now safer, more reliable and easier to handle because of computers. That's the way the future of the health care system and the handling of information will be.

I'm sure many believe that such a bold assertion is just not feasible. Some nonbelievers may be saying, "Ray is off his rocker". Others, who are far in advance of my knowledge and insight, are probably asking why I am boring you with this infantile discussion on computer capabilities and informational technologies. Bottom line, you ask, what should we as individual practicing physicians do to prepare ourselves, and what is CMS going to do to help?

First, as individuals, we need to become computer literate. No, we don't need to become expert computer programmers. We just need to understand what computers can do for us. Perhaps most importantly, we must be open minded enough to accept the changes and learn how computers can help us to practice the best possible medicine.

We also need to familiarize ourselves with some of the new communication technologies. The easiest way to do this is to hop on the Internet, visit the web sites and become familiar with how this technology works.

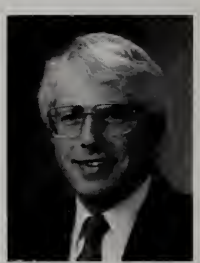
What can CMS do for you? First of all, we are working to enhance the ease, education and value of this familiarization for our members. Second, CMS is acting on the recommendations from various committees and task forces to help guarantee that the "good" data which is being transferred to physicians, truly is quality data. CMS can assist in organizing and making the data available as needed. Finally, CMS must play a role in ensuring that the correct data is being collected, properly interpreted and utilized. Bad data has to be exposed for what it is.

Someone once said, "If you torture data long enough it will confess". Physicians must start torturing the data that is being used against them, and in turn doctors must strengthen the data that is being used for them by becoming more familiar with it. Stay tuned.

LEGAL UPDATE

from Gelt, Fleishman & Sterling P.C.

Partnership Accounting



A. Craig Fleishman, Managing Director

The recent Colorado Court of Appeals case, Tafova v. Perkins, is of interest to partners withdrawing from a partnership formed under the laws of the State of Colorado. In that case, Mr. Tafoya effectively withdrew from a partnership in which he was a partner in July of 1989. In January of 1994, the assets of the partnership were sold at a profit. Immediately prior to the sale of the partnership property, Mr. Tafoya filed a complaint in a Colorado district court alleging an interest in the proceeds from the sale of the property. The request for relief asked, among other things, for an accounting of the sale proceeds.

The appellate court found that Mr. Tafoya's claims for an accounting and for a transfer of a portion of sale proceeds to him were barred by the applicable statute of limitations. In particular, that appellate court held that, once Mr. Tafoya ceased to be associated with the partnership, not only did this dissolve the partnership, it also caused the two-year, "catch-all" statute of limitations to begin to run on any claims he might have for an accounting and for portion of the partnership's profits.

Consequently, because Mr. Tafoya had not filed his complaint until January of 1994, more than two years after his withdrawal from the partnership in July of 1989, his claims for an accounting and for a portion of the partnership's profits were time barred. For further information please contact:

A. Craig Fleishman, Managing Director
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...a compilation of medically-related news briefs of immediate interest to the physician community occurring after ***COLORADO MEDICINE*** has gone to press. ***AT PRESS TIME...***

CMS Med Fax®
by ***Montgomery Little and McGrew, P.C.***
legal counsel to the Colorado Medical Society

CMS introduces new member service: Publication of prescription pads

As a member physician of the Colorado Medical Society, you know that CMS advocates for you and for patients. The society's motto, "Advocating excellence in the practice of medicine," is not just a slogan for you, it is a creed. That creed may be one of the primary reasons why you are a member. Unfortunately, many patients and the general public do not realize that your membership in CMS is important. What can you do to inform your patients about this commitment to them?

CMS has an answer. This month CMS will begin a new member service; prescription pads will be printed for member physicians on an "at-cost" basis. Prescription pads may be the last mode of communication that you would think about when attempting to convey how important the medical society is for public health, legislative reform, and standards of care to your patients. However, the small slips of paper can be a vital first step in elevating the awareness about CMS, and initiating a conversation with your patients about your commitment to them through membership in the society.

Pads will contain pertinent information, including your name, practice address and phone number. More importantly, the CMS seal and the phrases "Member of the Colorado Medical Society" and "Physicians advocating for their patients for over 126 years" will appear on each pad. Every time your patient, your staff, pharmacists and other health care professionals see your prescriptions they will know that you are a proud member of the society that has been helping to shape the structure and function of health care in Colorado for over one and one-quarter centuries.

Your membership does count. It is important to make your patients, member and non-member colleagues and the public know about your commitment to quality health care in the state of Colorado. Little things, like prescription pads, can help increase that level of awareness.

Please see the ad on page 20 for more information.

Call for excessive processing and delayed claims testimonials

The CMS Health Care Financing Department has received a number of calls from members voicing concerns over ongoing problems they are experiencing with insurance companies. In order for CMS to analyze the scope of the problems, identify any patterns and determine the best way to assist members, we need to hear from more of you.

If you too are experiencing excessive claims processing and payment delays, or your claims are "lost", please send us a letter briefly outlining the specific insurance companies and the problems associated with each. Letters should be addressed to:

Colorado Medical Society
Attn: Marilyn Rissmiller
P.O. Box 17550
Denver, CO 80217-0550.

Forum on the Medically Indigent Planned for March 7, 1997

Dr. Gary VanderArk, CMS President-elect, is planning a forum on caring for the medically indigent. Entitled: *Caring for Colorado's Underserved*, the forum is scheduled for March 7, 1997 from 8 a.m. until 5 p.m., just prior to the CMS Interim meeting at the Hilton Hotel Southeast in Denver. This dynamic and interactive conference will address challenges for providers of care; innovative models of care and financing; the roles of managed care, hospitals and foundations in the provision of care to this population. The forum will also assist in identifying a direction for Colorado in the provision of care to the medically indigent. Registration for the conference is included on the Interim Meeting registration sheet on page 23. Put the date on your calendar and watch for more information.



Med Fax: Medico-Legal News

by Karen B. Best, Esq., an associate with the law firm of Montgomery Little & McGrew, P.C.
This column contains information concerning topics of general interest in the medical-legal field. For further information or help with specific problems, please contact Montgomery Little & McGrew, P.C.

"The minute you read something you don't understand, you can be almost sure it was drawn up by a lawyer."– Will Rogers

Independent Medical Examinations: Now you see a duty to the patient; now you don't

Once and for all: Can a doctor performing an independent medical examination be held liable to the patient for "harm" resulting from the examination? The answer simply put is: Yes and no. It depends.

The 1993 Greenberg case tells us that, even in the absence of a traditional physician-patient relationship, a doctor conducting an independent medical examination owes a duty of care to a patient not to refer the patient for treating of a type that, based on information known to the doctor, forseeably will result in physical injury. Dr. Greenberg allegedly referred the patient for a functional capacity evaluation, knowing she had a bad back. She later claimed her back was injured during the evaluation, and sued Dr. Greenberg for negligently ordering the evaluation.

Although the holding in Greenberg is quite narrow, the case has come to stand for the broader propositions that, in general, (1) a doctor performing an independent medical exam (IME) owes a duty to the patient to conduct the examination in a manner which will not cause physical injury to that person, and (2) the doctor may be held liable for harm arising from negligence in the performance of the IME.

What if the harm is not physical injury arising from negligence in the performance of the independent medical examination, but rather emotional suffering arising from the publication of a false report of an evaluation? Is there a duty? Is there potential liability? Yes, under some circumstances.

The 1988 Montoya case (which arose in the context of a visitation dispute during divorce proceedings) tells us that physical injury is not required to trigger a mental health care provider's duty to the patient/client and is not required to trigger potential liability to those harmed as a result of the erroneous contents of a report. In Montoya, a psychologist's assistant made an inaccurate report to county officials and others that a father had sexually abused his daughter. Concluding that the father could maintain an action against the psychologist and his assistant, the Colorado Court of Appeals held that a psychologist owes any person who is the subject of any public report or other adverse recommendation by that provider, a duty to use due care in formulating the opinions upon which the report or recommendation is based.

In both cases, the Court found a duty running between the health care provider and the person examined or evaluated, even though there existed in neither case a traditional physician-patient or psychologist-patient relationship: in one case the "harm" was in the nature of physical injury resulting from an allegedly negligent referral for tests; in the other case the "harm" was in the nature of more nebulous emotional suffering and reputational damage resulting from the reporting of negligently false accusations of sexual abuse.

You might see a trend favoring a duty running from the health care provider to the person being examined or evaluated, or who will be affected by the provider's report. Not so fast.

What if a patient claims a doctor who performed an IME owed her a duty to use due care in formulating opinions, conclusions, diagnoses and recommendations that the no-fault insurance carrier – which hired the doctor to perform the IME – relied upon to deny her no-fault benefits for further treatment of alleged injuries? The patient claims that because of the doctor's negligent misdiagnosis, recommendations and conclusions in his IME report, the insurance carrier wrongfully withheld no-fault benefits and the patient could not obtain necessary treatment. The patient does not claim that she was physically injured while undergoing the IME, only that she was injured as a result of the IME doctor's conclusions which resulted in a denial of benefits and delay in treatment.

Does the doctor owe the patient a duty under these circumstances? Is the doctor potentially liable to the patient for harm if the insurance company denies benefits? Although the facts are similar to those in Greenberg and Montoya, the result is different.

The Colorado Court of Appeals recently held that a doctor's duty to use reasonable care in making and preparing an IME report runs to the party requesting the report, not to the patient. Doctors performing IMEs are not liable for harm arising from the opinions and conclusions reached as a result of their examination of a patient referred for IME. See Martinez v. Lewis, 20 Colorado Journal 1725 (Colo. App. 1996). The court draws a distinction between physician injury resulting from the examination itself versus other types of harm (such as economic injury or the denial of benefits) resulting from the IME doctor's opinions and conclusions about the patient's condition, prognosis and the medical necessity of treatment. As a practical matter, patients cannot maintain lawsuits against IME doctors based solely upon the opinions and conclusions stated in their IME reports.

In making a determination about whether duty or liability may attach, the court engages in risk-benefit analysis and looks closely at (a) the nature of the services performed by the doctor, (b) the circumstances surrounding the request for services, and (c) any information gleaned by the doctor from the patient during the IME. If a physician retained by an insurance carrier to perform an IME limits his or her contacts with the patient to an evaluation of the patient's condition, prognosis, and necessity of treatment, and prepares a report for the sole benefit of the insurance carrier, the patient and doctor have not entered into a physician-patient relationship of the type found in Greenberg.

Other factors in the Martinez case weighing against the creation of an IME-based physician-patient relationship or a

(See Medical Exam next page)

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(Medical Exam cont. from page 2)

duty include: the absence of an implicit or express contract for professional services between the patient and the doctor; the patient did not seek medical advice or treatment from the doctor and none was provided; there is no evidence the doctor failed to inform the patient of some unknown condition; the doctor was retained solely by the insurance carrier to review the patient's past medical records, perform his own examination, and report to the carrier what the doctor believed to be the diagnosis, prognosis and other information about what treatment, if any, was necessary; the agreement between the carrier and the doctor was solely for the benefit of the carrier; at no time did the doctor advise the patient of a recommended course of treatment; the patient knew nothing of the doctor's qualifications, background, or the nature of the services he would render; and, the doctor disclosed up front that the information obtained during the exam was not confidential and that a report would be given to the insurance carrier. Additionally the patient was not injured during the IME.

Remember, the physician still owes a duty of due care to the patient to avoid physical harm, when the harm is foreseeable. If the doctor undertakes to treat or otherwise provide medical care to the patient the physician may by his or her words or actions, expressly or implicitly contract to exercise reasonable and ordinary care and diligence to fulfill that purpose. That's the rule from Greenberg, and it hasn't been changed by Martinez.

The Martinez decision stresses the importance and social utility of allowing no-fault insurance carriers to request IMEs performed by doctors of their choice as part of the investigative process designed to allow carriers to make informed decisions about whether to deny benefits, and designed to resist false and unfounded claims. The decision recognizes that, "One possible repercussion of imposing a duty of due care upon an independent medical examiner is the risk that experts would be less willing to make independent conclusions and opinions adverse to the examinee for fear of being subject to liability...The social utility of independent medical examinations producing informed decision-making and policy by insurance companies outweighs the possible consequences of imposing a duty. Balancing these factors weighs against establishing a duty of due care (toward the patient) under the circumstances here".

Be aware that the decisions reached in each case are fact specific: a different set of facts can result in a different conclusion about the existence of a duty and liability for harm.

As always, be careful out there. For more information contact me at Montgomery Little & McGrew, P.C.

CMS members win national offices

Two CMS members have been elected to national office in recent weeks:

Amilu S. Rothhammer, M.D., general surgeon, has become the first woman ever to be elected to the American College of Surgeons Board of Governors. Her term as Secretary to the Board runs through October, 1997.

David M. West, M.D., family practitioner, was elected in October to a three-year term on the Board of the American Academy of Family Physicians (AAFP). Dr. West practices in Grand Junction. He said he was desirous of winning a board seat with AAFP "because I think I can be a positive force for change in American medicine".

In Dr. Rothhammer's new position, she will be a member of the ACOS Executive Committee, and she will serve as chair of the Committee on Fiscal Afffairs for the Board of Governors. Drs. Rothhammer and West are both members of Copic's Board of Directors.

Immunization Information Alert!

Each September the CMS Department of Health Care Policy, as a service to CMS members, mails any new immunization information to physicians who have indicated an interest in receiving the materials. A mailing was done recently and many of the packets were returned for lack of a sufficient address. Staff is updating the database for this particular project and requests that you call to let us know if you would like to be included in next year's mailing. Also, if you did not receive a copy of the 1996 -1997 Influenza information form, and would like one, please call Suzi Shevell at 779-5455 or 1-800-654-5653.

Correction

The November 1996 edition of *Colorado Medicine* mistakenly reported that Stephen B. Whitehead, MD, had become a new member. Dr. Whitehead has been a loyal member of CMS and the Boulder Medical Society since 1964.

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Colorado Medical Society provides the following listings of events as a member service only. Some events are approved for Continuing Medical Education credits. Information is provided by the sponsoring organizations. For more details, use the telephone contact at the end of the listing.

Dept. of Labor, Div. of Workers' Compensation & University of Colorado School of Medicine
Medical Treatment Guidelines Seminar
February 6, 1997
Colorado Springs, Colorado
For registration information call (303) 777-8182
Other questions call Cynthia Borries at (303) 575-8802

American College of Cardiology
Cardiovascular Conference at Snowbird
February 12-14, 1997
Snowbird, UT
1-800-253-4636 ext. 695

Colorado Hospital Association
Preparing for the DOJ: DRG 3-day Window Project Prg.
February 14, 1997
Denver, Colorado
Contact: Peggy McCreary at (303) 758-1630

American Lung Association of Colorado and the Colorado Trudeau Society
36th Annual Durrance-Waring Mid-Winter Chest Conf.
February 19-22, 1997
Aspen, Colorado
CME credit: 10.75 hours in Category 1 AMA
1-800-586-4872 or (303) 388-4372

Dept. of Labor, Div. of Workers' Compensation & University of Colorado School of Medicine
Medical Treatment Guidelines Seminar
February 21, 1997
Thorton, Colorado
For registration information call (303) 777-8182
Other questions call Cynthia Borries at (303) 575-8802

Colorado Society of Osteopathic Medicine
Ski & CME Midwinter Conference
February 23-28, 1997
Keystone, Colorado
CME Credits: 39 hours AOA Category 1-A CME crdt
Patricia Ellis (303) 322-1752 or 800-527-4578

American College of Cardiology
4th Annual Workshop on 2-D and Doppler Echocardiography at Vail
February 24-27, 1997
Vail, Colorado
1-800-253-4636 ext. 695

Dept. of Labor, Div. of Workers' Compensation & University of Colorado School of Medicine
Medical Treatment Guidelines Seminar
March 15, 1997
Denver, Colorado
For registration information call (303) 777-8182
Other questions call Cynthia Borries at (303) 575-8802

American Lung Association
16th Annual Big Sky Pulmonary & Critical Care Med. Conf.
March 20-22, 1997
Big Sky, Montana
(406) 442-6556

The Prosper Meniere Society
6th Symposium and Workshops on Inner Ear Medicine and Surgery
March 22-29, 1997
Aspen, Colorado
Contact: Jane Wells, (303) 788-4235

Dept. of Labor, Div. of Workers' Compensation & University of Colorado School of Medicine
Medical Treatment Guidelines Seminar
April 3, 1997
Grand Junction, Colorado
For registration information call (303) 777-8182
Other questions call Cynthia Borries at (303) 575-8802

Colorado Hospital Association
19th Annual Rural Hospital Conference
April 30-May 3, 1997
Breckenridge, Colorado
Contact: Peggy McCreary at (303) 758-1630

American College of Cardiology
Clinical Cardiology Management and Diagnostic Dilemmas
April 30-May 2, 1997
Santa Fe, New Mexico
800-253-4636, ext. 695

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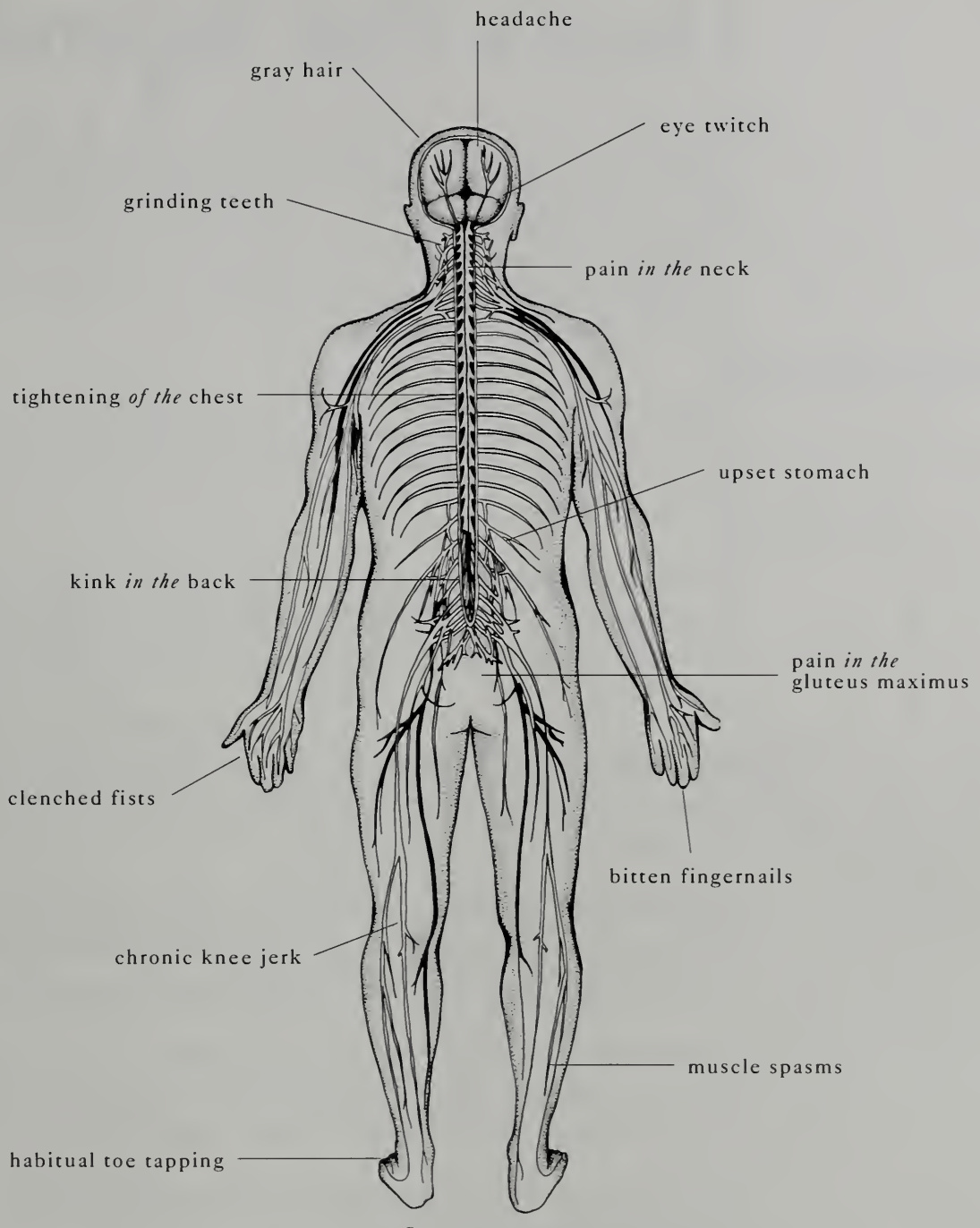


Figure 23

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Here's Our Agenda

It's simple. It's straightforward. And it represents the future of medicine. The American Medical Association presented to the Republican and Democratic leadership this agenda for the upcoming 105th Congress. Your AMA membership strengthens our voice in support of physicians and their patients. . . and will enhance our efforts to turn these goals into reality.

- **Patient Protections** Above all, preserve the ability of physicians to act as advocates for their individual patients. Do not allow insurers to "gag" physicians or withhold medically necessary treatments from their patients.

- **Medicare Reform** Make the Medicare program solvent. Expand patient choice of plans. Allow future growth rates that cover patients needs. Retain special protection for the vulnerable and elderly.

- **Medical Education and Research** Continue to support medical education and research so we can find cures for killers such as AIDS and cancer.

- **Public Health Problems** Expand prevention and treatment programs to combat AIDS, drug abuse, smoking and violence. These problems cost billions of dollars and millions of lives.

- **Liability Reform** Enact meaningful liability reform to ensure fair compensation to patients with legitimate claims while eliminating excessive malpractice awards that lead to defensive medicine.

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Executive Director's Update



by Sandra L. Maloney
Executive Director
Colorado Medical Society

Medically speaking, January is a pivotal month, the month around which the rest of the year will turn, rotate, move, spin, or gyrate, based on what the legislature does.

January is also the first month of another year under managed care. Where is it taking us and what will it do for the patient? For the physician?

January introduces another busy schedule of buyouts and mergers in the healthcare field.

We have made early progress on most fronts. As you will note in this issue, CMS and the CHMOA have reached an accord on continuation of care through patient transition from one health care program to another. That's a big step and we're very happy it has been accomplished.

You will also notice in this issue a recap by Dr. Leigh Truitt (CMS Managed Care Consultant) of where managed care has taken and is taking the practice of medicine.

They may not all be listed in this issue, but there are many new mergers and combinations afoot, with physician groups and hospital medical staffs combining in new networks.

I have the feeling that there are so many BIG things happening to medical practice all at once that we tend to lose sight of the separate issues and give in to being steamrolled. For instance, while "Managed Care" is touted as a major nemesis of the private practice, that's only one part. Corporate gluttony leading to the swallowing up of hospitals and medical practices alike are another major assault on the profession. Legislation is another factor altogether, and every physician needs to be a part of the effort to direct legislators and to protect themselves and their patients in the lawmaking arena.

If we take these fronts one at a time, things have not really changed that dramatically over the past five years. It is only when we allow ourselves to give in to the combined threats that the future seems rather hopeless.

As we start this new year the Colorado Medical Society has efforts under way on each of these fronts. The Council on Legislation is formulating positions on "intractable pain and building a campaign concerning proposed Medicaid law.

At the same time, the CMS-CHMOA Committee continues its meetings to further solidify cooperation between physicians and the managed care groups (17 represented by the CHMOA). This has been no easy task; the committee was put together by Drs. David Martz and Joel Karlin almost three years ago, and it has served the CMS membership well, last year developing the ***White Paper on Physician Affiliation/Disaffiliation.*** That was a first, nationally, and it led to legislation in Colorado that protects the physician and the patient. And now, the committee has hammered out the latest, the ***Principles for Transition of Patient Care.***

The ***"Physician Profiling Project"*** is another extremely important effort of this organization. I urge each of you to support it by making the profile information available to your patients. CMS is here, ready and willing to help you get that word out. Through the support of Copic Insurance and Gadrian Corporation, the project is in place; we just need to educate the patients to its availability and usefulness. If you don't know how you can help, call in; we'll show you.

"Medically speaking, January is a pivotal month. . ."

Corporate gluttony is something else; we will have to learn to live with it as major national corporations buy up local hospitals, form groups, create their own managed care networks, etc. The "merger mania" is going to continue, and the likelihood of a single corporate owner in health care looms ever closer. Well, remember, we didn't like "Nationalized Medicine" either. How much different is this threat?

Well, there you have it: the Update! And we're all still here (CMS) waiting to hear from you. We're just a phone call away . The CMS divisions are listed in the front of this book, with phone numbers and e-mail addresses. Now, we're even going on the Internet with a CMS home page and links to bountiful information resources. We're easy to get to; give us a call, send an e-mail, or make a "hit".

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Richard Allen, MD, Chairman
CMS Council on Legislation

Greetings for another year. It's hard for me to believe that the '96 elections are now behind us and the legislature is set for another banner year. The Council on Legislation has had it's first meeting, and I am pleased to report that I have a Co-Chair. It was my feeling that after two years as your Chair, it was perhaps time for me to step aside and make way for some "new blood". After discussions with leadership, a compromise was reached. Dr. Chris Unrein will join me as Co-Chair. Dr. Unrein has served on the Council very faithfully for the past two years, he will become the Chair for the Council on Legislation next year.

The Council has already dealt with a number of resolutions which have been referred from the 1996 Annual Meeting of the House of Delegates. Work has begun on many of these issues.

Results of the 1996 elections and their impact on the legislature have been reviewed. It is important to reiterate how the passage of Amendment 15 will dramatically affect organizations and political action committees, like CMS and COMPAC. Campaign contributions will be restricted. Therefore, we will need to have a **much stronger** grass-roots effort from all of the members of CMS in order to maintain legislative key contacts.

New legislation on Medicaid reform is expected. The Council also expects to see some new bills relating to data collection from health care providers. Consumer groups may propose disclosure and consumer protection legislation from the various insurance entities involved with managed care. Written properly, CMS would be very interested in supporting such legislation. The usual bills from alternative providers seeking to expand their scope of practice and prescription writing privileges are anticipated. Several groups are reviewing potential bills regarding the various treatment aspects of intractable pain. In addition to some other HIV legislation, the Council on Legislation forsees some legislation regarding HIV testing for pregnant women and newborns. Despite the resounding defeat of Amendment 17 (the Parental Rights Initiative) at the polls, the Council expects at least two bills regarding parental notification. Other legislation to prohibit funding of birth control for the indigent may be coupled into these bills.

Once again, the Council on Legislation has a full plate of legislative issues. We will try to keep you well informed of what is happening. Since there is always some delay between when this column is written and when you get to read it in print, it is always wise to call the Government Relations Department at CMS for the latest up-to-date information.

We at CMS are looking forward to another interesting year and will be calling on you for help on specific bills and issues. Together we can make this another successful legislative year for the Colorado Medical Society.

"Once again, the Council on Legislation has a full plate of legislative issues."

Where is Managed Care taking the medical profession?



By ***Leigh Truitt, M.D.***

". . .you may not do this - - - you should do this, and we will help . . ."

For years the medical profession has regarded managed care as an external force that attempts to restrict the autonomy of physicians and other health care providers in order to lower the costs of care. Certainly first generation utilization review - including pre-certification, concurrent review, second opinions and retrospective review - has basically meant the denial of services, i.e., it has been a proscriptive process. Money can be saved in this manner (at least if the alternative is pure indemnity insurance) without denying appropriately necessary visits, tests and procedures. However, this form of early managed care operates without much in the way of participation by those who actually provide the services. The criteria are purchased off the shelf and applied without the consent of the governed.

The "low hanging fruit" of utilization review has now been picked in most areas. In the future, for further improvements in both the cost and quality of care, the medical profession must become actively involved in managed care. This will require three principal changes in the paradigm of utilization management.

The first change is direct physician involvement in medical necessity decisions. Rather than use the blunt instruments of commercial systems of criteria, physicians must use judgment and discretion in making the close calls necessary to limit services without impairing quality of care. When cutting close to the bone, we would all want the scalpel to be wielded by a well-informed, well-intentioned professional rather than an industrial robot.

The Three Changes

- Physician involvement in medical necessity decisions.
- Physician developed compensation systems.
- **Prescriptive** rather than **proscriptive** managed care.

The second change is physician developed compensation systems. Financial incentives involving the costs of care will surely be present in the future as they have always been in the past in both fee-for-service and capitation. These systems must be under the design, control and monitoring of the medical profession. Physicians do respond to financial incentives as does everyone else, but they also have other motivations. Systems devised by outside agencies are seldom able to balance the conflicting motivations of health care professionals in a manner that best meets the needs of the patients, the professionals and the health plans in assuring high quality and low cost health care.

The third change is to move from a proscriptive approach to health care - you may not do this - to a prescriptive approach - you should do this, and we will help you do it. This may not always be the least costly approach in the short run. After all, it always costs more to do something than to do nothing. But most of us do agree with that

Managed Care (Continued)

famous commercial for oil filters - "pay me now or pay me later." The Total Quality Movement has convinced most of us that doing it right the first time costs less in the long run.

Practice guidelines, practice parameters and algorithms all tell you what you should do. In a certain sense they also tell you what you should *not* do, but the main thrust is to positively prescribe an approach to a clinical problem. This is a long way from telling a physician that he may not do this test or procedure. After all, if a visit, test, procedure or hospitalization is unnecessary, to deny it doesn't mean that whatever concern precipitated the apparent need has gone away. How much better to guide you in approaching the problem by exploring options than to tell you that you can't do what you thought should be done and then walk away!

Health care is both subtle and unique. Rarely are problems so stereotyped that one size fits all. Nevertheless, we have left the era in which the best practices were those that did more - more visits, more tests, more procedures and more hospitalizations. On the other hand, it is certainly not always true for health care as Mies Van Der Rohe said about architecture: "Less is more". We are entering a time when discriminating clinical judgment about what to do will be more important than ever.

Managed care has been in a dark age of loss of autonomy in which decisions appeared to be made from mysterious collections of criteria dispensed via 800 numbers. We are entering a new enlightenment in which independent clinical judgment will use evidenced based medicine to make decisions that have the most favorable outcomes for patients, physicians and health plans. We are moving from alchemy to chemistry. As physicians, we need to be involved in a positive way at every stage with our own utilization management, compensation systems and guidelines.

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Colorado Physician Network, Inc.



by David C. Maartz, M.D., President
Colorado Physician Network (CPN)

1997 is the year of Realization! The time has come for Colorado Physicians' Network to "Make it Happen!"

Two years ago in January, 1995, Colorado Physicians Network (CPN) was only a dream--a vision of the Colorado Medical Society Leadership. We were collecting $100 contributions to explore whether a patient-friendly, physician-directed bold move in Health Care was feasible. The answer was "Yes": CPN was formed and joined with Rocky Mountain HMO (RMHMO) to create Rocky Mountain Physicians' Choice (RMPC). Fertilization had occurred.

One year ago in January, 1996, we were recruiting the physician panel. Over 2100 physicians have subsequently joined, and we have recently expanded our panel of Primary Care Physicians by contractual arrangements with RMHMO providers in the Denver-Metro area. Marketing has been initiated in the Southern Front Range, the Eastern Plains, and Northwest Colorado. Gestation has come to full term.

Now we are poised to give birth to our statewide program. Marketing in the Denver-Metro area is imminent; the Medicaid product has been approved and Medicare expansion is pending. *"Peer-A-Med"*, our state of the art utilization review system, is in place, and Disease State Management guidelines are in development.

Born at last as a model of "How it **SHOULD** be Done" we must all bring life to RMPC. It will not live and breathe spontaneously. . . it will need nurturing if it is to grow to maturity and strength.

Let us therefore resolve together that we will one and all spread the news and excitement of "Our Bold Move": tell your patients, refer employer-purchasers, and offer healing should growing pains occur.

It is ours for the making. **This is the year we must**

"MAKE IT HAPPEN!"

Recognition

*by **Bill Pierson,** Managing Editor*

"....receiving his M.D. degree at age 21."



W. Gerald Rainer, MD

It is difficult to find something to give a man who has almost everything... who has done almost everything? That is certainly the case with W. Gerald Rainer, MD.

Probably the best thing is to give him recognition. He has earned it.

He is recognized for the fact that this year marks his eleventh and retiring year as president of the Colorado Medical Society Education & Research Foundation (CMS-ERF). Earlier, Dr. Rainer was recognized as an outstanding cardiothoracic surgeon in Colorado, and a visiting professor and guest lecturer at many prestigious institutions throughout the world.

Dr. Rainer gained recognition and appreciation from many medical students at the University of Colorado School of Medicine where he has been Clinical Professor of Surgery.

Recognition in medical practice came after Dr. Rainer spent ten years with the Denver Clinic and then elected to enter solo private practice, where he spent his next 20 years.

During this period, Dr. Rainer gained further recognition by serving for 6 years as a director on the American Board of Thoracic Surgery, and as a member of numerous professional societies and past president of many, including the American College of Chest Physicians, the Denver Medical Society, and the Colorado Medical Society.

Unusual circumstances surrounding Dr. Rainer's life attracted attention early on; he was taught by his mother at home, and rather than have him start 1st grade she insisted that he begin in 3rd grade, which partially accounts for his receiving his M.D. degree at age 21.

He was born in a little town of Gordo, Alabama, and that earned him some recognition because any addition to the population of 800 was notable. To add to the notability of his life, Jerry started Emory University in Atlanta at the age of 16. Theology was his major, but he soon transferred to the University of Alabama in pre-med. He received his Bachelor's Degree in 1945, and then worked his way through medical school at the University of Tennessee, receiving his MD in 1948.

In 1952, Jerry volunteered for the Army and was soon sent to Korea. Most of his time there was spent in the front lines, where he received the Bronze Star for bravery in action.

After Korea, he elected to pursue a career in thoracic surgery. He took his general surgery training at Denver's VA Hospital, cardiothoracic surgical training at University of Colorado School of Medicine, Denver General Hospital, Children's Hospital, and Fitzsimmons Army Hospital and the VA Hospital.

In addition to all this, recognition should certainly be paid his wife of 46 years, Lois. Certainly also of note are their four children and their collective families.

Now, we come to the real reason for all this recognition heaped on these pages. In 1985, midst the other activities of his busy life, Dr. Rainer became President of the CMS Education & Research Foundation (to that time the Immediate Past President of CMS automati-

cally became ERF President for one year). However, the CMS leadership chose to make this an elective position, and Dr. Rainer held the post for 11 years, but this is the year he is retiring. He is retiring from full-time medical practice and he is retiring from the CMS-ERF Board.

Recognition? For what? For the fact that the CMS-ERF has, under his leadership, grown from $23,591 in 1988 to $46,350 in 1996, and has awarded a grant of $6,500 to Aurora-Adams County Task Force on the Medically Indigent, five scholarships to medical students of $5,000 each, a $2,000 grant to CPEP, and has extended a total of eight loans to 4th-year students amounting to $12,000. All but $900 of this total amount had been repaid as of January, 1993. Loans were discontinued in 1993, and replaced by the outright grant program.

Each year, since 1988, CMS-ERF has contributed $500 per year to the Colorado State Sciences Fair, and each year ERF contributes $5000 to the CMS Educational Program.

CMS-ERF is a 501(c)(3) foundation and is funded by gifts and contributions. Your gift is tax-deductible, and a great way to start the new year would be to make a contribution or gift to CMS-ERF, Colorado Medical Society makes a gift in the name of each deceased member of the organization. The

A particularly good way to do this would be to make your gift in the name of W. Gerald Rainer, MD. It would be recognition well deserved. Send your gift to:

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Cooperation

Colorado HMOA (Health Maintenance Organization Association) and Colorado Medical Society agree on Principles for Transition of Patient Care

Patients with special needs who are required to move from one health care plan to another will be assured continuity of care from the physician at each end of the transition, thanks to a new protocol created by the Colorado HMO Association and the Colorado Medical Society.

The "Recommendations for Transition of Care for Patients With Special Needs" follows months of discussions between the Colorado Medical Society, representing some 5,200 Colorado physicians, and the HMO Association, whose 17 member organizations provide health care plans for 1.1 million Coloradans.

The recommendations apply specifically to those patients with chronic or protracted illnesses, and provide a framework which is simple and flexible.



Steve O'Dell, President
Colorado HMO Association

Steve O'Dell, President of the Colorado HMO Association, President of HMO Colorado, and Executive Vice President of Blue Cross and Blue Shield of Colorado said, "Our highest priority is member satisfaction. This agreement reaffirms that decisions about appropriate care will be between doctor and patient, and there is an understanding about how the new plan should be advised about the care required by the patient".



M. Ray Painter, MD.
President, Colorado Medical Society

Colorado Medical Society President M. Ray Painter, MD., added that, "The agreement goes a long way in assuring continuous quality care for patients with special needs that are forced to shift from one health care plan to another. Its adoption by individual HMOs will provide a mechanism for a smooth transition without interruption".

RECOMMENDATIONS FOR TRANSITION OF CARE FOR PATIENTS WITH SPECIAL NEEDS AND CIRCUMSTANCES

PREAMBLE

In the process of transitioning of care from one health plan to another, at times it becomes necessary for a patient to leave an ongoing doctor-patient relationship during treatment of a chronic or protracted medical condition and establish a relationship with a new physician. There is great value to the care of the patient in developing a process to facilitate such transfer with minimal disruption to all involved parties.

The recommendations presented herein are designed to recognize the special needs of certain patients with chronic or protracted illnesses who are under the care of either a primary care or specialty care physician at the time of transition. They provide a preferred method by which the patient interacts with the two physicians at both ends of the transition and the new health plan. They provide a framework which is simple and flexible, compensates the transferring physician for the time and effort expended, gives highest priority to concern for patient satisfaction, and promotes an effective vehicle for health plans to transition potentially high cost patients into their plan.

Developed through discussions between the Colorado Medical Society and the Colorado HMO Association, these recommendations are presented to health plans and physicians for their voluntary adoption.

RECOMMENDED ELEMENTS OF TRANSITION

1. **EARLY NOTIFICATION.** Typically a patient who will be changing plans involuntarily will have a time delay between the notice of change and the effective date. The patient should advise the current physician practice as soon as possible.

    A. Health plans should make available: (1) A written description of the process used to facilitate transition of care, (customer service, new member nurses, etc.) (2) a written description of its review process of requests to continue services with an existing, non-affiliated provider.

2. **IDENTIFICATION OF PATIENTS WITH SPECIAL NEEDS AND CIRCUMSTANCES.** Current physicians are expected to identify patients with unique needs and initiate a process to facilitate their transition to a new provider.

    A. Health plans should make available to those patients so requesting, available participating providers (primary care and specialty practices) and how to contact them to ease referral and selection.

    B. If requested by the patient, it is appropriate for the current physician to suggest a physician to the patient, and then begin communication with that physician.

3. **TRANSITION PLANNING VISIT.** The current physician and patient should schedule a visit in the period before effective date of new plan to plan a smooth transition to the accepting physician's practice.

4. **TRANSFER OF PATIENT INFORMATION.** The current treating physician should: (A) Collect and prepare for transfer of adequate medical records to inform accepting physician of patient's past medical history, treatment modes, medication history, pertinent diagnostic measures, current treatment plan, etc. and, (B) create a letter of referral summarizing pertinent historical and biographical data to facilitate accepting physician's development of rapport with the patient and family.

5. **INTRODUCTORY VISIT TO ACCEPTING PHYSICIAN.** Should be arranged as soon as practical after effective date of new plan. The current treating physician should make a recommendation to the patient regarding the timeliness of scheduling the first appointment. The purpose is to begin development of relationship, ensure pertinent records are available, prescriptions are transferred if necessary and consideration of ancillary needs (durable medical equipment, etc.).

6. **PHYSICIAN TO PHYSICIAN CONSULTATION.** It may be appropriate for former and accepting physicians to formally consult regarding patient's unique needs.

7. **COMPENSATION.** Fair and appropriate compensation should be paid promptly for each of these services by the plan in effect at the time of service.

8. These recommendations should also apply when a physician is separating from a health plan. When: (A) The physician is voluntarily leaving the plan, the physician should initiate the transition process. (B) The plan initiated disaffiliation, the health plan should initiate the transition process.

Can organized medicine unify?

by Joel M, Karlin, M.D.
Member, Federation Coordination Team
AMA Alternate Delegate



"Would such collaboration . . . occur spontaneously? Not a chance!"

Can we forget when Clinton's Health Plan divided national specialty societies from our AMA? Or when a major county medical society instructed their lobbyist to oppose the Colorado Medical Society's position on corporate practice of medicine at the State Capitol?

These recollections of the split in organized medicine's public posturing have led to a joint effort on the part of all components to form a "new federation" of medicine. For over two years representatives of AMA, county, state, and specialty societies met to begin restructuring organized medicine in a way that retains the fundamental characteristics of individual physician members and independent organizations while moving the federation in a direction of functioning in a more coordinated and efficient manner.

The key purpose of the new federation should be to increase the value of membership of all federation components for all physicians and to achieve maximum unity of voice and action on behalf of physicians.

Achieving increased value for members will require streamlining roles to reduce duplication. Role clarification and collaborative efforts should be the highest priorities in implementing the new federation.

The AMA House of Delegates reviewed the reports of this work group, and in June, put into place mechanisms and strategies to begin creating the new, streamlined, interactive federation.

Would such collaboration so envisioned occur spontaneously? Not a chance! The AMA House recognized that to initiate such a process would require an energized group representing the organizations that make up the federation, incorporating the characteristics of the physician population.

Following solicitation to all federation components, a team of 26 of us was selected by a special selection committee. Our appointment is for three years during which time we will act as a catalyst and facilitator of change in organized medicine. We will try to leverage the strengths and resources of individual organizations, helping each to meet their members' needs in more efficient and cost-effective ways.

It will be absolutely imperative that we help to break down the feelings of mistrust, and this can best be achieved by creating a forum for honest and frequent exchange of ideas. Decision-making by consensus will be our goal, putting aside parochial interests to work for the greater good of medicine. When true consensus is unachievable, demonstration of respect for all organizations as peers will allow us to venture forward to discuss new issues.

To begin the process of more intimate collaboration, we will begin evaluating and implementing demonstration projects for joint activities. Some projects will look to eliminate duplication and other inefficiencies while others will hopefully provide new programs and services. Work groups have been assembled to explore opportunities in communication technology, joint dues billing, and physician accreditation,

We have an unprecedented opportunity to forever change how we, as physicians, and our organizations interact with one another. Please Contact me with your suggestions. Are there demonstration projects you might suggest to help us achieve our goals? FAX them to me at 303-789-2766, or E-mail them to JKarlin600@aol.com. Together we **CAN** make a difference.

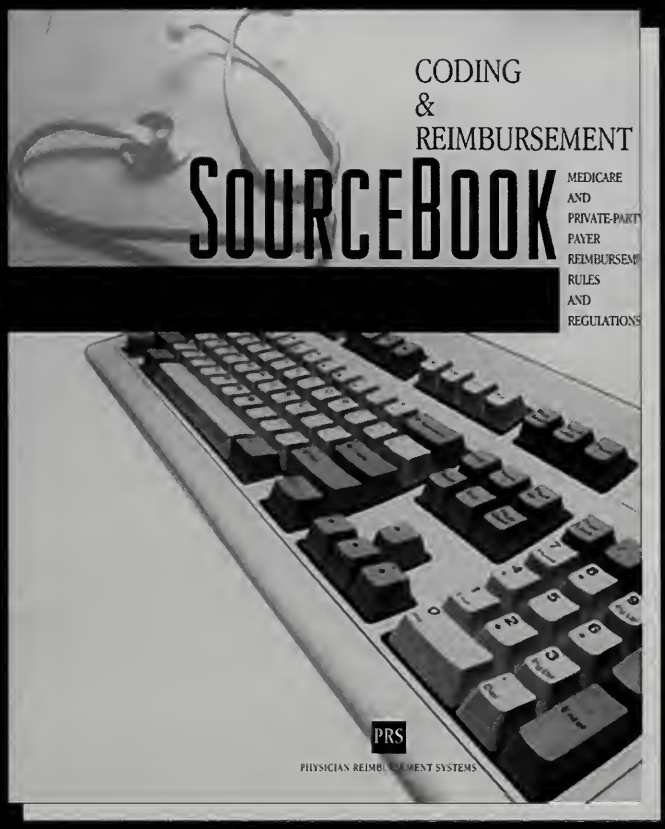
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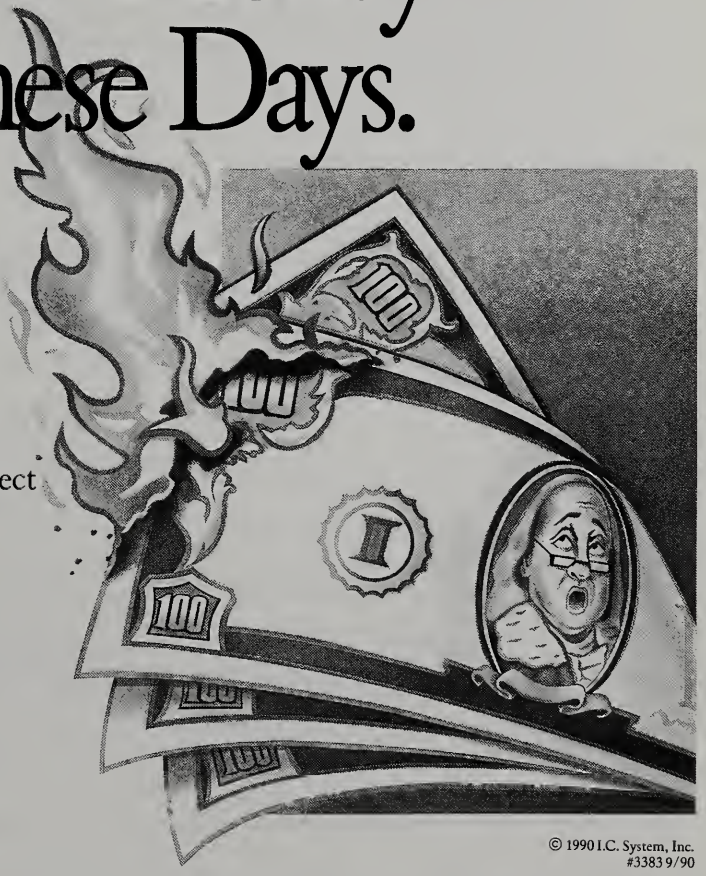
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CopicComment

by Jerome M. Buckley, MD
Chairman & CEO
Copic Insurance Company



Capitation Offers You a Chance to Regain Control (Huh?)

At a recent meeting of the Claims section of the Physician Insurers Association of America (PIAA), I had the opportunity to hear a presentation by James Saxton, Esq., of Barley, Snyder, Senft & Cohen, LLP of Lancaster, Pennsylvania.

Like so many other speeches and seminars these days, Mr. Saxton's presentation dealt with the consequences of capitated managed care. What I found so compelling -- and what I'd like to share with you -- was his unique approach to the topic. According to Mr. Saxton, we physicians can complain all we like about this particular type of healthcare delivery system. The hard truth, he says, is that our complaining will change nothing and that we would better serve ourselves and our patients by using that energy to determine how we will respond. Rather than eroding your control, he says, capitation offers physicians a unique opportunity to regain control over their practices and over the delivery of health care in this country.

The facts, says Mr. Saxton, are these:

- In order to remain competitive, HMOs are racheting down the premiums they charge their members and are agreeing to cover an increasing range of services.
- In order to retain their patient bases, physicians who want to stay in business are agreeing to provide those services in exchange for decreasing capitation payments.

Statistics show that if capitation reaches 32% in a delivery system, volumes must increase 30% to compensate. Whether you agree or disagree with capitation, says Mr. Saxton, you cannot dispute the foregoing facts. Neither you nor Copic can dispute the resulting risk such a system creates as profit margins shrink, resources become scarce, and a new way of practicing emerges.

I like to separate the risks that result from capitation into the **"Whos"**, the **"Whats"**, and the **"Wheres"**.

The "Whos" are primarily concerned with the increasing need to utilize mid-level practitioners or those with even lesser training. Not only are knowledge and experience at issue, but credentialing and licensing also come into play since the physician is ultimately responsible for the actions of those he/she supervises.

The "Whats" are the disease management systems being promulgated on several fronts, with their diagnostic pathways, care pathways, and endless protocols. These systems are rarely patient-friendly or physician friendly; moreover, they have the real potential to be a challenge for the risk manager and a treasure trove for a plaintiffs attorney on the lookout for miscues.

Finally, the "Wheres" deal with the reality that care once delivered only in an ICU is ever more commonly being performed in the wards, in the medical office, and even at home. (Perhaps it isn't too farfetched to think that this type of care may move into the telemedicine arena some day, especially since it already has in certain military settings.)

The current situation is indeed unsettling, but I am convinced that there is good news for physicians. You see... our strength is that in this whole confusing mess, we are the only players capable of seeing "the big picture" -- not the court system, not the managed care organizations, and not our patients. We must educate ourselves about the arenas in which we now deliver our skills. If there is a flaw or a risk, we must find it, fix it, and figure out how to prevent it the next time.

I want you to know that you are not alone in this. Copic is committed to assisting you as you educate yourself and formulate your response to capitated managed care. Our managed care seminars are designed to help you understand recent system changes, our Managed Care Task Force is charged with identifying and resolving potentially sticky managed care issues, and we will continue to work with groups such as the advanced practice nurses to help you improve patient care, reduce your risk exposure and survive (and even thrive) under capitated managed care.

Colorado Medical Society
1997 Interim Meeting

Holiday Inn Southeast
(Parker Road @ I-225)

Schedule

Friday, March 7, 1997

8:00 a.m.-5:00 p.m.	*Caring for Colorado's Underserved* Conference
1:00 p.m.-2:00 p.m.	Finance Committee
2:00 p.m.-5:00 p.m.	Board of Directors
5:00 p.m.-6:00 p.m.	Registration
5:15 p.m.-5:45 p.m.	Cocktails
5:45 p.m.-7:30 p.m.	*Caring for Colorado's Underserved* Dinner

Saturday, March 8, 1997

6:30 a.m.- 4:00 p.m.	Registration
7:00 a.m.-10:00 p.m.	Office open
7:00 a.m - 8:00 a.m.	Reference Committee Members
7:00 a.m.- 8:15 a.m.	AMA Delegation Open Forum
7:15 a.m.- 8:15 a.m.	COMPAC Board
8:00 a.m.- 8:30 a.m.	Credentials Committee
8:30 a.m.- 9:00 a.m.	House of Delegates - Opening Session
9:00 a.m.-12:00 Noon	General Membership Meeting
12:15 p.m.- 1:45 p.m.	Luncheon
2:00 p.m.- 4:00 p.m.	Reference Committee
3:00 p.m.- 5:00 p.m.	Reference Committee

Sunday, March 9, 1997

6:30 a.m -10:30 a.m.	Registration
7:00 a.m.-12:00 noon	Office open
7:00 a.m.- 8:30 a.m.	Arapahoe caucus
7:00 a.m.- 8:30 a.m.	Aurora-Adams caucus
7:00 a.m.- 8:30 a.m.	Boulder caucus
7:00 a.m.- 8:30 a.m.	Clear Creek Valley caucus
7:00 a.m.- 8:30 a.m.	Denver caucus
7:00 a.m.- 8:30 a.m.	El Paso caucus
7:00 a.m.- 8:30 a.m.	Larimer/Weld caucus
7:00 a.m.- 8:30 a.m.	Pueblo/Western Slope caucus
8:15 a.m.- 8:30 a.m.	Credentials Committee
8:30 a.m.- 12:00 noon	House of Delegates - Closing Session

Meeting Registration and Hotel Reservation Forms are on the next page.

This portion goes to CMS

Interim Meeting Registration

1997 Interim Meeting of the Colorado Medical Society, March 8-9, 1997, Holiday Inn Southeast

Name (***Please type or print***) _____

Name of Spouse/Guest (if attending) _____

Component Society _____ Office Phone _____

Reservations for Events and Meetings

(***Reservation deadline is February 21, 1997.*** Reservations accepted on a first-come, first-served basis)

		Number Attending	*Cost*	*Amount Enclosed*
Friday, March 7, 1997				
8:00 a.m.-5:00 p.m.	Caring for Colorado's Underserved Conference	_____	Free	
5:45 p.m.-7:30 p.m.	Caring for Colorado's Underserved Dinner	_____	$20	$ _____
Saturday, March 8, 1997				
12 :15 pm –1:45 pm	Luncheon	_____	Free	

Hotel Reservations

Please use the hotel reservation form below to make your reservations directly with the Holiday Inn Southeast. **The deadline for room reservations is February 21, 1997.** The preferred rate will be extended to CMS members on a space available basis after February 21.

Meeting Registration

Please submit a registration form by Februrary 21, 1997, if you plan to attend this Interim Meeting. We're delighted to receive it by mail, fax, or phone. We can check you in more quickly and efficiently if you've preregistered, in addition to providing more accurate and therefore cost-saving guarantees for our food functions. Thanks!

Messages

The hotel's phone number is 303-695-1700. (You may want to leave this number with someone.) If you need to be contacted, ask the hotel operator to transfer the call to the CMS registration desk or CMS office.

What To Do

Complete this entire form and return it to Colorado Medical Society, by mail to: PO Box 17550, Denver, CO 80217-0550, by phone to: 303-779-5455 or 1-800-654-5653 or by FAX to: 303-771-8657.

This portion goes directly to the hotel

Hotel Reservation Form

Colorado Medical Society
Interim Meeting
March 8-9, 1997

Please Reserve _____ Rooms for _____ Person(s)

Name _____

Firm _____

Address _____

City/State _____ Zip _____

Will arrive on _____
Day Date Time

Will depart on _____
Day Date Time

Credit Card _____
Name Number Exp. Date

Type Room—

Single 1 person	$68
Double 1 Bed 2 persons	$68
Double 2 beds 2 persons	$68
Suite	$125

Extra Charge per person _____

No. Persons Adults _____

Children _____

Check One

❑ 6 pm ❑ Guaranteed

Estimated time of Arrival at Hotel _____ Sharing with _____

Current lodging tax is 11.8%. Group cutoff date is 2/21/97. Reservations will be held until 6:00 pm Denver time, unless accompanied by a first night's deposit or guarantee of payment to a major credit card (please include expiration date). CHECK IN TIME IS 3:00 PM, CHECK OUT TIME IS 12:00 NOON.

Return form to: Holiday Inn
Attn: Reservation Department
3200 S. Parker Rd., Aurora, CO 80014

FAX: 303-745-6958

Or Call: 800-962-7672

by John Lightburn, MD
Historian
Colorado Medical Society



Gentleman Jim

"Misfortune well-bourne is good fortune."
-Marcus Aurelius



James J. Waring, M.D.
1883-1962

As the 21st Century approaches, we in the medical profession face daunting challenges that may bring to pass greater changes in our professional lives than have occurred since Robert Koch's discovery of the tubercle bacillus. Following Koch's example, medical scientists continue to change our lives with new tools and techniques that seem almost miraculous. At the same time, social, political and economic forces are creating profound changes that threaten to rob our profession of its very soul. Can history provide us with guidance to survive the coming upheaval with our integrity intact? Let us examine the life of one of our early teachers, James J, Waring, MD. Perhaps his example can guide us.

James J. Waring had wanted to be a doctor for as long as he could remember; the Warings of Savannah, Georgia had produced doctors for generations. His great-grandfather, William R. Waring (1787-1842) a graduate of the University of Pennsylvania Medical School (1813), was well known in Savannah as a physician, meteorologist, community leader and an authority on yellow fever and malaria. His second son, James Johnston Waring (1829-1888) also was a graduate of the University of Pennsylvania Medical School and after some graduate studies in Dublin and London joined the faculty of the Colombia Medical School in Washington, D.C. He and his bride built a home and had their first three children while in Washington. With the coming of the civil war, while basically a Unionist, his loyalty to family prompted him to return to Savannah. Despite the deprivations and trauma of the war, Annie, their eldest child, grew into a bright, beautiful and strong-willed young woman, the toast of Savannah society (and Annie will be the focus of our attention). She met a dashing young Spaniard, Antonio Gogorza and fell in love with him. It was not long before she decided to marry him in spite of her father's strong objections. Gorgoza and Annie moved in with her parents which created a crowded household in which the hostility between son-in-law and father-in-law flourished. After four years of marriage, strife and the birth of two boys, Antonio and James, the older James Waring ordered his errant son-in-law out of the house. After the ensuing divorce, Annie took back her maiden name and asked the court to change her son's name to Waring. Thus, Antonio and James were raised by a single mother with the help of two other women, Aunt Mary and Grandmother. Annie undertook the task with resourcefulness and fierce determination. Education was of the greatest importance and they were destined to carry on the Waring family tradition. After prep school in New Jersey, they were sent to Yale and then to medical school, Antonio to the College or Physicians and Surgeons at Columbia University and James to Johns Hopkins University School of Medicine in Baltimore.

Hopkins was a new school when Waring was admitted in 1904, and it assembled a young and vibrant faculty: William Osler in medicine, age 39; William H. Welch, pathology, age 38; Howard A. Kelly, obstetrics and gynecology, age 31; and William H, Halsted, surgery, age 37. A famous faculty, dedicated to teaching, placed heavy demands on the students. No longer were lectures alone sufficient; long hours in the laboratory, wards and clinics were demanded of each student, and James responded with an obsessive concern about not doing well enough, not ever knowing all there was to know. He completed the pre-clinical years with high marks and high hopes.

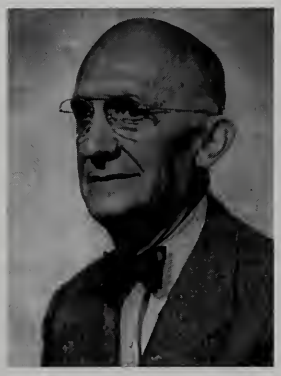
But the long hours, demanding schedule and concern for his clinic patients began to wear him down. He lost weight, tired easily and slept poorly. He persisted and pushed himself, denying himself any time off

for recreation or rest. Finally, in March, 1907, he saw his physician, Dr. Rufus Cole, who found a low grade fever, a few rales in the left chest: and "a few tubercle bacilli" in the sputum.

James wrote a letter to Annie in Savannah trying to reassure her (and himself) that it was an early case and the prognosis was not all that bad. But he had to leave school for at least a year and was advised to go to Edward Trudeau's Sanatorium at Saranac Lake, New York. Annie came to Baltimore immediately and together they went to Saranac Lake.

Trudeau was a wonderful physician with many years of experience with tuberculosis, the nation's outstanding specialist in the field. He was compassionate and humane and attended to the emotional needs as well as the physical. Waring initially improved, but his temperature remained unstable, his fatigue seemed worse and his depression was profound. And the winters at Saranac Lake were relentless. He later admitted the experience there was a good medical education. Although one dour physician had told him he would not get well, James was more determined than ever, and he and his mother headed for Colorado.

In May, 1908, James travelled west by train with mother, aunt and brother. When he arrived in Colorado Springs, he had to be carried off on a stretcher. He was soon admitted to Cragmore Sanatarium where he began the slow return to health and was discharged sometime in 1910 to live with his mother. He continued to improve and learned the joy of fly fishing. His dedication to medicine remained strong. Rather than return to the east and risk a reoccurrence of his disease, he decided to stay in Colorado and resume his studies at the University of Colorado in Denver where he received his M.D. degree in 1913. He then served an eight month internship at St. Luke's Hospital, and a four month residency at the Agnes Phipps Memorial Sanitarium several miles east of Denver, later the site of Lowry Air Force Base. In 1914, he was appointed part time instructor at the Medical School and served on the staff of the tuberculosis dispensary, both non-paying positions. He began his private practice as an associate of Sherman Grant Bonney, a prominent specialist in tuberculosis (a Southerner working for Sherman Grant!). He often made his rounds to the several sanataria and hospitals on his bicycle. He contributed to the Denver Medical Society library and became the society librarian. In 1917 he was elected into membership of the Denver Clinical and Pathological Society which met monthly in the Grill Room of the Brown Palace Hotel. His first paper, "Progress in the Study of Diseases of the Chest" was published in this journal (***Colorado Medicine)*** in 1917.



Dr. Waring, circa 1950

He appeared to be pushing himself as he had when a student at Johns Hopkins. Was he headed for another episode of "TB?" The country had entered the war in Europe, physicians had enlisted, and the work for those left at home doubled. Then came the influenza epidemic of 1918 and 1919 and the endurance of every physician was stretched to the breaking point. Waring again became a patient with influenza and then pneumonia. With his history of TB, he knew he had to care for himself so he closed his practice, took a leave of absence from the medical school and rested for a full year.

Now he had time to think of something else besides work. He met Ruth Porter, youngest daughter of Henry M. Porter, and after a courtship of over a year, they were married on June 15, 1921 in St. Martin's Chapel. This was truly a fortunate union for both Ruth and James. He had never been happier nor more secure. His depression no longer burdened him; Ruth's loving care was the perfect antidote. His love of work and his sense of humor returned. Adding to his joy, two daughters were born: Ruth in 1922 and Anne in 1923,

By this time, he had left his association with Dr. Bonney and had become associated with Dr. Leonard M. VanStone with offices in the Metropolitan Building in downtown Denver. It was a busy and gratifying general practice with a special interest in tuberculosis and diseases of the chest. His teaching responsibilities at the medical school increased with his elevation to assistant professor in 1926, a position with more prestige but still no pay. Nevertheless, his passion for teaching increased, and his participation in grand rounds one evening each month was enjoyed by students and faculty alike. He became a strong advocate in published papers for public health measures and participated in community organizations. Between 1925 and 1930 he was president of the Allied Health Council, Denver Public Health Council, Denver Sanatorium Association, Denver Tuberculosis Association, Denver Medical Society and the Colorado Association for Mental Hygiene. In his presidential address to the Denver Medical Society, he took the society to task for its lack of concern in public health matters, the poor attendance at meetings, the poor quality of the scientific papers presented and the general lack of participation by most members. In 1928, he published a paper describing the health hazards of tobacco, probably the earliest effort to alert the public to the dangers of smoking.

In 1932, the faculty and Board of Regents approved of his elevation to Professor of Medicine and Chairman of the Department of Medicine, the first full time chairman of the department. The position was without pay and remained without pay for a decade. Only Franklin

(Continued on following page)

(Continued from preceding page)

Ebaugh, chairman of psychiatry, had a paid full-time clinical faculty position. That Waring stayed on with no pay for over ten years is a measure of his devotion to teaching and the welfare of the students. He followed the Hippocratic Oath very seriously. As chairman, he was able to gather an outstanding faculty to the department, all unpaid, volunteer positions. They included Ward Darly, Robert Ligget, Abe Ravin, Thaddeus Sears, Dumont Clark and Charles Karfman. So in spite of restrictions by a miserly Board of Regents and state legislature, he built a fine department. With these volunteers, he was able to maintain his department through the years of World War II. And through it all, he maintained his sense of humor and his delight in teaching and treating patients. In 1951, he stepped down from the Chairmanship after nineteen years and in 1952 retired from active teaching, becoming professor emeritus. He was truly one of the great men of Colorado medicine and many of us owe him a great debt for his efforts on our behalf.

So what is the lesson that this great man gives us for the 21st century. There are many possibilities. One lesson is that he found the ideal balance of love and work in his life, not only the love of his wonderful wife but also the love of his students and patients. He had a goal and a passion which was apparent in his work and play. And that is what made the difference. He was involved with his fellow physicians through various organizations, agencies and societies.

Author's Note: The above fails to truly describe the rich life of James Waring. A Medical Gentleman by Patricia Paton is the source of most of the information in this article. You will find this book a delight to read and a source of inspiration.

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CPHP serves the needs of the Colorado medical community through problem identification, treatment referral, monitoring, clinical consultation and support to individuals and their families.

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The Colorado Physician Health program is a non-profit organization established by the Denver and Colorado Medical Societies. These physicians recognized that organized medicine had an important role in physician health: identifying and rehabilitating physically or emotionally distressed and impaired physicians.

C.R.O.P. Report



by Peter B. Milstein, Consultant

Excerpted from the Executive Summary of the CROP planning study

The Colorado Medical Society (CMS), through its Colorado Rural Outreach Program (CROP) Advisory Committee, requested that Development Associates of Colorado (DAC) provide a planning feasibility study regarding their desire to conduct a capital campaign for the purpose of building an endowment that would help place physicians with outstanding educational loans in the rural underserved areas of the state.

Seventy-eight individuals representing physicians, businesses and corporations and a broad cross section of the Colorado philanthropic community were interviewed. After careful analysis, DAC has applied its own professional fund raising experience which resulted in the following summary.

Many of those interviewed expressed a concern regarding CMS's proactive activities over the past few years on behalf of the statewide community of physicians and patients, and believe that programs such as CROP are a step in the right direction. The general awareness in both the rural and urban communities regarding the need for physicians in rural areas is amazingly high throughout Colorado. Almost all regarded this as a project needing to be addressed since little has been accomplished in this arena in the past.

Interviewees given a tentative case statement felt the proposed program design is a good start but would need some fine tuning before it is acceptable for serious consideration. To begin, the need for a statewide program must be fully justified and quantified by means of generally accepted statistics and demographic data. In addition, the program must address *retention of physicians in the community, and continuing medical education opportunities.* Finally, the general consensus is that, due to minimal experience of the CMS and CROP Advisory Committee with respect to fund raising, and the prevailing reputation physicians have for not being philanthropically inclined, two objectives must be accomplished in order to successfully implement the fund raising goal, and ultimately, the program: *1) Seek to build a coalition of leadership with the rural communities, businesses and corporations, other members of the health care industry, the foundations, and the legislature for both the capital campaign effort, and the program implementation, and 2) Involve and educate physicians so that a significant lead gift to the capital campaign can be generated prior to any other solicitations. This lead gift should be in the range of $300,000 to $500,000.*

The general opinion of those interviewed is that a well coordinated and funded statewide coalition effort, with the involvement and participation of those organizations mentioned above, will have the best chances of meeting the needs of the state of Colorado. Interviewees expressed two concerns regarding the $1.5 million campaign goal: 1) the size of the goal may be too small to sufficiently cover all of the program needs, and 2) the potential for CMS to abandon efforts to seek assistance from the Legislature. Indeed it may take more than $1.5 million to get the CROP up and running. Therefore, the goal should probably be enlarged to around $5 million, with the expectation that it can be reached in three to five years in two phases. It may well take several years to bring the Legislature into a partnership with the CROP, but collaboration should be sought through members of the coalition seeking to forward the CROP.

The results of this study show that CMS and the CROP Advisory Committee are not likely to be successful in reaching the financial goal unless those segments of the community deemed to be the beneficiaries of the program (physicians, rural communities, the health care industry, medical education institutions, businesses and corporations, and foundations are incorporated into a coalition to support the program and its fund raising campaign.

The general belief of those who participated in the study is that if the physicians can generate the lead gift, other gifts from the statewide community will be obtainable.

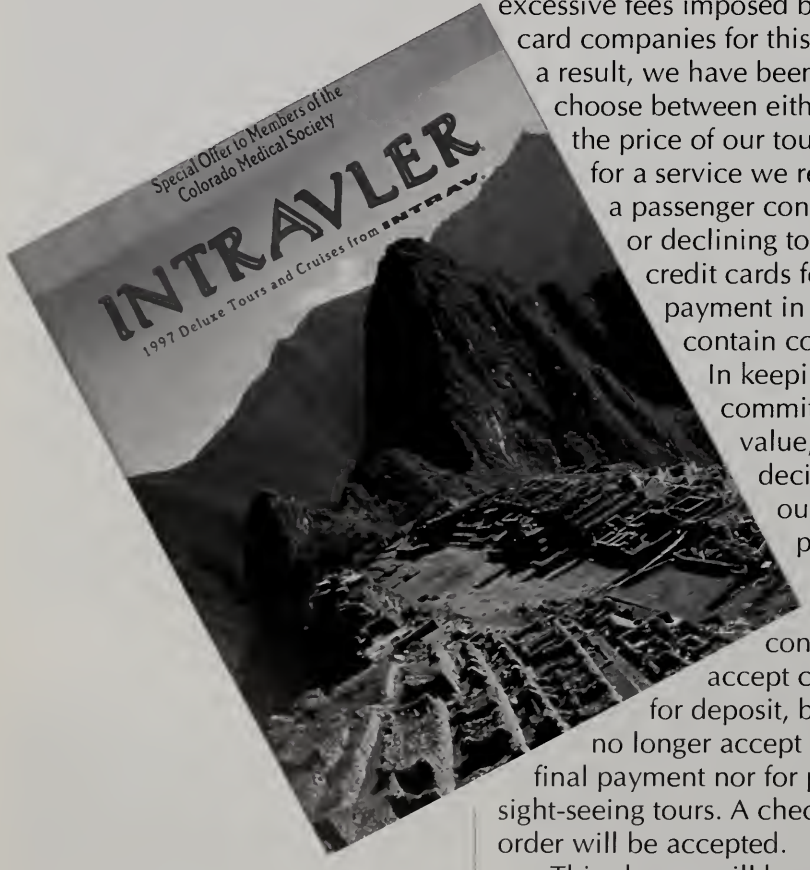
DAC believes that this effort can be successfully achieved if the suggested modifications are acceptable to the CMS and are implemented prior to launching any of the programmatic or campaign activities.



Ric McCune
Regional Vice President
INTRAV

In reference to **INTRAV's acceptance of credit cards for travel and tour payment**

"In keeping with our commitment to value. . ."



To the members of Colorado Medical Society:

Throughout our 37 year history, **INTRAV** has continually searched for ways to enhance our services and yet maintain value in our tour and cruise products.

Cost containment is a major consideration where value pricing is concerned. One item which has required our careful review is the issue of acceptance of credit cards for final payment because of the excessive fees imposed by credit card companies for this service. As a result, we have been forced to choose between either raising the price of our tour products for a service we recognize is a passenger convenience, or declining to accept credit cards for final payment in order to contain costs.

In keeping with our commitment to value, we have decided to alter our final payment policy. We will continue to accept credit cards for deposit, but we can no longer accept them for final payment nor for prepaid sight-seeing tours. A check or money order will be accepted.

This change will become effective with **INTRAV**'s Spring, 1997 programs. All booked passengers will receive a written notification concerning our policy. It also will be clearly stated in future trip brochures and Travel Information Leaflet.

We hope that you concur with this policy decision, and we appreciate your continued support of our travel offerings.

Thank you, Ric. Colorado Medical Society has enjoyed a long and rewarding association with **INTRAV**, and we have elected to continue that relationship through the coming year. The fact that certain changes must be made on the part of **INTRAV** for passenger payment "goes with the territory," and we can only hope that this change in policy does not create a hardship on any CMS member.

An additional note to CMS members about travel programs in 1997, if you have not received (or possibly received and misplaced) the 1997 ***"INTRAVLER"*** , please contact the Communications/Member Services Division of CMS (303-930-0418 or 1-800-654-5653) and we will see that you receive a copy.

This book represents another effort on the part of **INTRAV** in collaboration with CMS to provide CMS members with travel information without loading down the "IN" box every month with another brochure. The ***"INTRAVLER"*** puts the entire year's CMS travel programs together under one cover, making the information readable and more understandable.

Bill Pierson, Director
CMS Member Services

Coding Highlights

by Marilyn Rissmiller,
CMS Health Care Financing Department

Each new year brings coding changes for Medicare, and most other payers. As a physician, you and your office staff need to review the procedure and diagnosis codes you use frequently to see if any of these changes affect your billing.

- In most cases there is a grace period for adjusting to any changes in procedure codes (Medicare will accept the old codes until April 1, 1997, for dates of service January 1, 1997 through March 31, 1997).
- However, the grace period for the diagnosis codes was October 1, 1996 through December 31, 1996. Beginning January 1, 1997, Medicare requires that you use the new ICD-9 codes. (The Medicare bulletin for December 1996 included a listing of diagnosis codes that were no longer valid as of January 1, 1997.)
- The Medicare Carrier published a complete listing of the new and deleted HCPCS procedure codes and modifiers in their November 1996 bulletin. (Example: Modifier GB for distinct surgical procedure was replaced by CPT modifier 59.)
- In their December 1996 bulletin the Medicare Carrier published information on CPT codes which will no longer be accepted as of April 1, 1997, examples:
  - The CPT codes for destruction (17000-17105) have been replaced by new HCPCS codes G0051, G0052 or G0053.
  - The CPT codes for psychotherapy (90842-90855) have been replaced by new HCPCS codes G0071-G0094.
- The following coding changes do **not** have a grace period. These codes were **effective January 1, 1997**:
  - CPT code 94150, Vital capacity, total (separate procedure), is now considered a bundled service and is not separately billable to Medicare or the patient.
  - CPT code 97010, Application of hot or cold packs, is now considered a bundled service and is not separately billable to Medicare or the patient.
  - CPT code 80055, Obstetric panel, is no longer acceptable, you must use the CPT codes for the individual tests within the panel.
- For complete information on all CPT and ICD-9 additions and revision you will need to obtain the 1997 edition of these books.

If you didn't receive these bulletin, contact the Medicare Provider Service Department at (303) 831-1221. If you need information on ordering a CPT or ICD-9, or if you have other questions, you can contact Marilyn Rissmiller in the CMS Health Care Financing Department at 779-5455 or 1-800-654-5653, ext. 2428.

Are you ready for the new year. . . and the coding changes that come with it?

SAVE THIS and the following pages – listing the members of the 1997 Colorado Senate and House of Representatives, their mailing addresses and telephone numbers. These lists are published for the purpose of the Colorado Medical Society Government Relations Division Key Contact program. Thses contacts will be of vital importance to Colorado physicians during 1997. We urge you to **locate your district legislators and keep these numbers handy.**

Colorado Senate

Ben Alexander (R)
District 6
P.O. Box 1285
Montrose 81402
249-3211/866-4866

Don Ament (R)
Disrtict 1
Route 1, Box 142
Iliff 80736
522-8205/ 866-4866

Ken Arnold (R)
District 23
10187 Julian
Westminster 80030

Tillman Bishop (R)
District 7
2697 G Road
Grand Junction 81506
242-9230/ 866-3077

Tom Blickensderfer (R)
District 26
9 Parkway Drive
Englewood 80110
758-0146/ 866-2587

Ken Chlouber (R)
District 4
220 W. 8th
Leadville 80461
(719) 486-0008/866-4866

Mike Coffman(R)
District 27
P.O. Box 440740
Aurora 80044
671-6402/866-4866

Jim Congrove (R)
District 19
PO Box 357
Arvada 80001
851-8729/866-4866

Gigi Dennis (R)
District 5
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HIGHLIGHTS OF BOARD OF DIRECTORS MEETING - November 22, 1996

Copic : Dr. Jerome Buckley, CEO, Copic, reported that he has been working with Drs. Painter and Martz to find the best way to utilize the Internet. The Copic website is functional. Gadrian has been working with the county medical societies, credentialing organizations and with the American Medical Accreditation Program (AMAP). He reported that Dr. Richert Quinn has returned to work after an extended illness.

Finance Committee: The Finance Committee requested approval from the board to set-up a fund to pay the first year membership dues for medical students joining CMS and AMA for the first time. The board agreed unanimously, and will make "out of pocket" donations.

Council on Legislation: Ms. Lorraine Koehn introduced Dr. Chris Unrein to the Board. Dr. Unrein is the new co-chair for the Council on Legislation. So far, there are twenty-five health related bills for the 1997-98 legislative session.

CMS Alliance: Ms. Stella Shanks reported that the Alliance meeting and the programs presented by Copic and Colorado Physician Health Program at Steamboat Springs were very successful. Ms. Shanks and Ms. Patti Brown have been traveling to the various Colorado counties to conduct meetings. The October SAVE Campaign was also successful. Ms. Shanks invited the Board to join the Alliance for a "Day at the Capitol" on Monday, March 3, 1997, between 8:00 am - 12:00 pm.

AMA Delegation: Dr. Painter stated that the AMA Interim Meeting will be held in Atlanta, GA, beginning on December 8,1996. He invited the board to view any of the Delegate Handbooks. The Colorado Delegation submitted a number of resolutions for inclusion during this meeting.

Medical Executive Group: Ms. Judy Ladd stated that the Medical Executive Group discussed the AMA AMAP during their meeting. Ms. Carol Walker, El Paso County Executive, has been invited to serve on the AMAP governing board.

Dr. Painter welcomed two new Board Members; Dr. Rod Holland from Larimer County, and Dr. Jarvis Ryals from Pueblo. The next Board meeting is scheduled for 2:00 p.m., January 24, 1997, at CMS offices.

Remember:

Your membership in COMPAC will assist with financing the campaign of legislators who are supportive of medical practice issues. 1997 is already a critical legislative year to medicine, so help however you can.

COMPAC

Medical Society receives grant to produce toxic environment exposure case studies

The American college of Occupational and Environmental Medicine (ACOEM) has received an initial $100,000 grant from the Agency for Toxic Substances and Disease Registry (ATSDR) to publish case studies of the detrimental effects of toxic or hazardous material exposures.

The award will support the first of a projected three-year program to develop and evaluate hazardous environment case studies that enable health professionals to protect their patients and communities. Among other studies, ACOEM will specifically target the effects of selected environmental conditions on children.

Saint Joseph Hospital named outstanding non-profit in state

Saint Joseph Hospital, Denver, was named Colorado's Outstanding Nonprofit Organization by the El Pomar Foundation's 1996 Awards for Excellence Program.

The hospital was recognized for its low-cost, high quality care, a new heart catheterization unit, its senior program and its Teenage Pregnancy Education Program. Saint Joseph Hospital received $25,000 from the El Pomar Foundation for being the chosen from among 35 finalists in 11 Awards for Excellence categories.

CMS-ERF scholarships awarded to two students

Two first year medical students have been awarded scholarships from the Colorado Medical Society Educational Research Foundation (CMS-ERF). Lana McCauley, from Woodrow, Colorado, and Lisa Cosens, from Carbondale, Colorado,



CMS-ERF President W. Gerald Rainer, MD, presents scholarship checks to Lana McCauley (l), and Lisa Cosens. Both are incoming students at CU.

each received a check for $5,000 to help pay for medical school. Since its inception in 1993, the scholarship program has helped students with high academic credentials and a financial need from rural areas pursue their dreams of joining the medical profession.

Historically, only one incoming student at the University of Colorado School of Medicine received the scholarship. This year CMS-ERF was able to award both scholarships, thanks to increased financial support for the foundation by CMS and its members.

CMS member receives prestigious Award

Stephen Berman, MD, of Denver, was honored by The City Club of Denver on December 17th. for his outstanding work on behalf of children in Colorado and internationally.

Dr. Berman, a CMS member, Professor of Pediatrics and Director of Health Policy at the University of Colorado Health Sciences Center and an attending physician at The Children's Hospital, has directly influenced state and federal legislation affecting the health and safety of children. He is the author of a acute respiratory infection management program that has been implemented in over 80 developing countries.



A. Gordon Brown (l) of The City Club of Denver presenting the James Grafton Rogers Award to Steven Berman, MD

The James Grafton Rogers Award is given annually to persons or organizations for "extraordinary and timeless achievement to the benefit of the people and physicial fabric of Denver". Rogers and Henry Toll, Sr., both Denver attorneys, founded the executive club in 1922.

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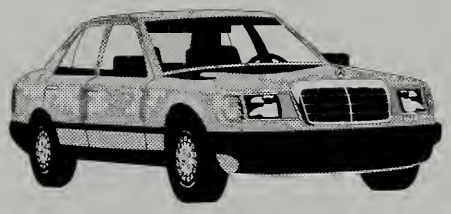
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Colorado Medical Society has endorsed Rocky Mountain Fleet Associates as a CMS member service, based on the satisfaction of the many physicians who have used their services over the past several years. These physicians have reported excellent results, **usually with savings of more than $1000 from even the best negotiated showroom price.**

For more details, call **(800) 864-4388.** In Denver, **753-0440.**

Colorado Medical Society

RUMINATIONS

(**def:** chewing again what has been chewed slightly and swallowed; to **REFLECT**)

*by **Bill Pierson**, Managing Editor*

"Come on out 'n fight!"

Those halcyon days of pre-cellular phones.

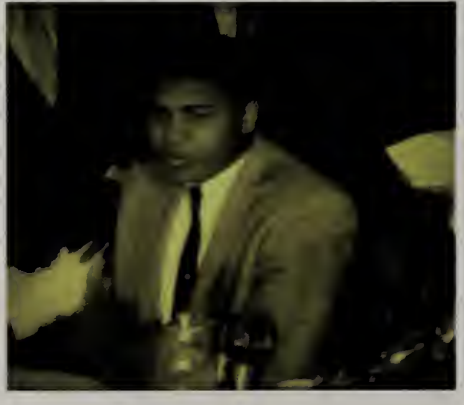
Speaking of telephones, the electronic age, communications in this new society, reminds me of an incident some years back. It was when a young boxer had just burst onto the professional scene. His name was Cassius Clay. He has little to do with this story, except to fix the era in your mind.

I had a two-way radio in my car. It was the tube-type developed during WWII, BS (before semiconductors). It was a tunable VHF radio; the channels were so crowded that we used the same band that the radio-telephones (pre-cellular phones) used. As a result, you could often tune across numerous of these channels and pick up telephone conversations, from car, home, or wherever.

It was a Sunday morning; I was on my way to the radio station. No one was bothering me. The two-way was quiet. There was a church service being broadcast on my station at the time, and I preferred not to listen to that. I tuned the two-way down the band and hit a ring-sound. I stopped to listen:
Female: "Hello"
Male: "Hi Babe"
Female: "Hi Honey! Where are you?"
Male: "In my car. I just got back."
(I was sure I recognized the male voice, and here I was eavesdropping, but I couldn't help myself. I had to see if I was right.)
Female: "How are you? You feel OK?"
Male: "Yeah... I didn't feel too good last night. Had an upset stomach, but I took a dose of Epsom Salts and I got to feelin' better. I got to go home. Maybe I'll lay down an' take a nap. I'll call you later, O.K.?"
Female: "Yeah, that's O.K. So you take care, now. Bye Sonny."

Bingo! I was right. Sonny Liston, the new EX-heavyweight boxing champion on Sunday morning, the day after the infamous fight in Las Vegas when he was accused of taking a dive in Round 1, giving the title to Cassius Clay. By the way, I never reported any of that conversation.

Clay was just a kid then... he was bumptious and seemingly rambunctious. He expertly crafted that image throughout his boxing career, just like he started out in Denver, driving down Monaco Blvd. at 2 am, using a loudspeaker to challenge Liston to **"come on out 'n fight!"**



If he were to start his career today, he'd just call on his cell phone. But then, maybe he wouldn't. You can't eavesdrop on today's phones as easily as you could the radio. So how would anyone know he had called?



Photos: Bill Pierson, November, 1963

And who is that man standing behind Sonny (above) when he and Cassius signed for their first match? None other than former World Heavyweight Champion Joe Louis, living in retirement in Denver. He was in Sonny's corner early on, but that credibility didn't last long. After being accused of throwing the fight in Vegas a year later, Liston never got the fan or hometown support his promoters had hoped for. In fact, his career was on the skids the day he hit the top.

Sonny died a lonely death in a California hotel room, allegedly OD'd on drugs, but he was never a user...not to my knowledge. He probably didn't even have a phone to call for help.

COLORADO MEDICINE

"Advocating excellence in the profession of medicine"

ruary, 1997 Volume 94, Number 2



Telemedicine? This is not a new brand of medicine. The tools have just changed! And there are a lot of them.



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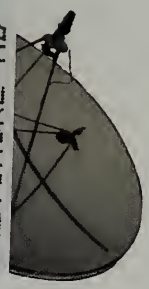
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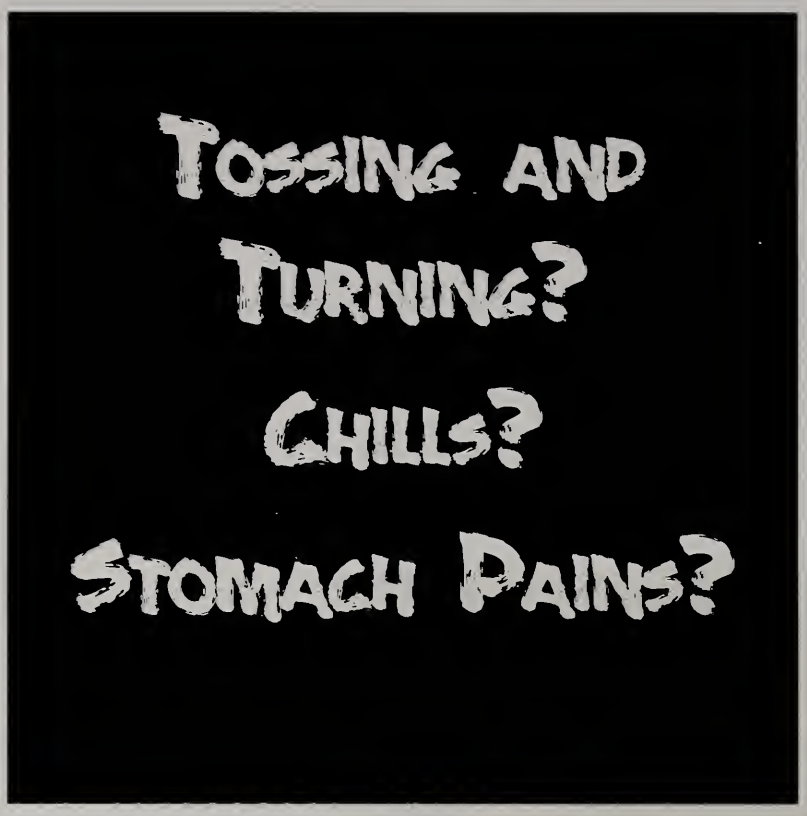


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pecial Section: The Future Is Already History - Starts Page 71

n This Issue:

Physician vs. physician? We need to take a step back by M. Ray Painter, MD ..... **page 45**
Two firsts in the "land of shadows" by Seymour E. Wheelock, MD ..... **page 55**
Risk behavior and communications by Kathy Gardner, Ph.D., Copic Insurance ..... **page 57**
Computers in Medicine! Are you kidding? by Claude S. Poliakoff, MD ..... **page 67**



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COLORADO MEDICINE

February, 1997 Volume 94, Number 2



Cover Story

This issue contains a Special Section made up of the many parts to today's telemedicine. As the many parts on the cover indicate, there is a lot to today's telemedicine.

See pg. 71-79

In This Issue...

45 **Collaborative Action, or do we work one against the other?** Generalist and specialist alike have two things in common: They're both physicians, and they both have to work with managed care.
M. Ray Painter, President
Colorado Medical Society

52 **"A Physician's Affirmation"**
Fredrick Ralph Abrams, MD

57 **Physician Self-Perceived Risk Behaviors and Communication** : A research study to examine physician communication behavior and a possible link with medical malpractice experience.
Kathy Gardner, BSN, Ph.D.
Assistant Vice President
Copic Insurance Company

61 **School of Medicine on the right course**
The Class of 2000: What will they face? Is the School preparing them for what lies ahead in medical practice?
Richard D. Krugman, MD, Dean
University of Colorado School of Medicine

67 **Computers in Medicine? Are You Kidding?** Why should we change? Does evidence-based medicine justify such a change?
Claude S. Poliakoff, MD
CMS Committee on Medical Informatics

71-80 **The Future Is Already History!**
SPECIAL SECTION
TRYING TO KEEP UP WITH THE REVOLUTION: A collection of articles, descriptions and points to consider in the age of telecommunication... not a new science; just revolutionary tools.

82-84 **CMS Interim Meeting:** Schedules, speakers and sign-ups

Departments

45 President's Letter
47 Executive Director's Update
49 The Lobby
50 AMA Update
54 Copic Comment
55 Archives
63 Member Services
64 Colorado Physician Network
70 Health Care Financing
86 Membership
87 Medical News
88 Classified Advertising
90 Ruminations

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Sandra L. Maloney, Executive Editor; William S. Pierson, Managing Editor; Chet Seward, Administrative Asst.

Member, Colorado Press Association, Member, Colorado Broadcasters Association



M. Ray Painter, MD
President, 1996-1997

Collaborative Action or Specialty vs. Primary Care, Physician vs. Physician

Organized Medicine: How and for Whom?

Are all of our physician organizations working in concert on our behalf? Or do we find at times that one organization is pitted against another? As you know these divisive confrontations, in which physicians testify against each other, create a split in the House of Medicine. More importantly they allow non-physicians to make critical decisions regarding health care. The transitional phase in health care that we are currently in has pitted physicians or groups of physicians against each other. This setting must change. We need to take a step back, focus on the big picture, and realize that our fellow physicians are not the enemy. The real enemy is the individual or group that is changing health care in a way that is not patient or physician friendly.

Change is possible. If physicians make the effort to work together, then we will be able to create a system which gives the patient the choice, the quality and the access that they deserve and eventually will demand. This change is much too important to allow the polarizing forces of Wall Street or other groups to divide the House of Medicine, and thereby make the decisions.

A good example of this internal strife is the gatekeeper concept. This issue should not splinter the House of Medicine, particularly the Colorado Medical Society. My reasoning is very simple. The main mission of Colorado Medical Society is patient advocacy. There are patients who love their primary care physicians and want that physician to choose their specialist and direct all of their care. On the other hand, there are patients who resent the gatekeeper model and would prefer to direct their own care and see the specialist of their choice each time they have an illness episode requiring care. Fortunately, there are managed care companies and physicians, both primary care and specialist, that believe in each of the two concepts. We should champion a pluralistic system which supports the concept , the activities and the comfort zone to allow both groups to exist side by side.

CMS must function as a forum to facilitate the discussion of differences between the specialties. A forum where solutions and consensus is developed which all physicians can support. To that end the CMS House of Delegates created the Collaborative Committee at the 1996 Annual Meeting. This committee will serve as a critical step in bridging the gap between specialty societies and CMS. It was devised with a format which prevents groups from ganging up and or forcing issues on one another. The concept is to negotiate and reach a common ground. Similarly, the Coalition of Physician Specialties Committee (COPS) was formed several years ago to allow all specialties in CMS to sit down at the table and discuss issues. Subjective pluralism is not a far-fetched fantasy. We can and must work even harder to make it a reality by unifying the House of Medicine.

Our physician organizations are reflections of ourselves. When the physician community realizes the true battle is not within the House of Medicine, when we can look at the big picture and see how we need to work together, then our organizations will begin to function on our behalf. Colorado Medical Society is striving to play its role to develop this collaborative action.

What are your thoughts? Please write letters to the editor, or contact me. I welcome your input. Please become involved!

"We need to take a step back, focus on the big picture, and realize that our fellow physicians are not the enemy."

LEGAL UPDATE

from Gelt, Fleishman & Sterling P.C.



A. Craig Fleishman, Managing Director

Protecting yourself after suit

Part I

In today's litigious society, it is likely that a process server will appear at your door to serve a lawsuit on you and your company. Although your first reaction may be anger or a desire to ignore the process server, the better reaction is to take immediate steps to protect yourself, especially if the lawsuit can be quickly dismissed.

Immediately contact your insurance carrier, and if none exists, your attorney, and forward all of the lawsuit papers to him or her. Time is critical, especially when you consider that the claimant has had as much time as necessary to prepare the lawsuit. A defendant must, under court rules, file a response or defense to a lawsuit within 20 days of receiving a complaint or risk having a judgement entered. Despite this shortage of time, a considerable amount of information must be accumulated and analyzed to properly defend a suit.

The first step is to completely communicate to your attorney all the known facts related to the lawsuit. This is most effectively accomplished by writing a chronological narrative of all the facts, event, conversations and explanations of what occurred. In explaining a conversation, you should discuss who said what, where they said it, when they said it, who was present, why they said it, and what was the response of the people who were parties to the conversation. Do not exclude anything! Let your attorney and the judge determine what is relevant.

Your narrative should be in letter/memo form addressed to your attorney personally. This information is confidential and protected by attorney-client privilege, which means that all communications between you and your attorney during your professional relationship are confidential, and, absent a waiver, opposing parties will have no access to them.

The alternative to such a narrative is spending many costly hours with your attorney orally recollecting facts, generally resulting in forgotten facts or misunderstandings. The practical result is that important facts will be overlooked which could potentially jeopardize defense of your case. A written narrative will significantly reduce legal fees as your lawyer will be able to review the information efficiently and quickly.

For further information contact:

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CMS Med Fax®

...a compilation of medically-related news briefs of immediate interest to the physician community occurring after ***COLORADO MEDICINE*** has gone to press. ***AT PRESS TIME...***

CMS Med Fax®
by Montgomery Little and McGrew, P.C.
legal counsel to the Colorado Medical Society

C.R.O.P. generating community interest

Community outreach for the Colorado Rural Outreach Program (CROP) is underway. Recently you read about a survey of needs that would be sent to individuals, clinics, hospitals, county health departments and community health centers in rural Colorado. The surveys are being returned, and as suspected there are many communities seeking physicians. Each respondent indicated that a program such as CROP would be helpful in assisting their efforts to recruit and retain physicians for their communities.

In addition to the survey, focus groups are being set up to gather more detailed information about specific needs in Colorado's rural areas. Once the information from both the survey and focus groups is compiled and reviewed, the next step will be to incorporate what has been learned into the program itself.

The Resource Development Committee for CROP has begun to assemble a group of physicians from all over the state who will educate CMS members about CROP. These education ambassadors play a vital role in the project. They will contact as many of their colleagues as possible to talk about CROP, in addition to building support and enthusiasm for the project. Physicians will soon be asked to contribute to the program. It is important that they understand the necessity and value of the project. CROP will not only benefit rural Colorado communities in need of physicians, it will offer doctors who want to practice in rural areas the opportunity to do so.

If one of your fellow members calls to ask you about CROP, please give them a few minutes of your time. If you would like to become an educational ambassador, or if you are interested in assisting with the project by learning more about CROP, please contact Suzi Shevell at 1-800-654-5653 or 930-0407. CMS needs your input and involvement in order to make CROP successful.

Dr. Lewin to keynote *Caring for Colorado's Underserved*

The Colorado Medical Society is sponsoring a special forum addressing the issues surrounding Colorado's medically indigent population. *Caring for Colorado's Underserved,* keynoted by John C. Lewin, MD, will be held on March 7, before the 1997 CMS Interim Meeting at the Holiday Inn Denver Southeast.

Dr. Lewin will address the growing problem of caring for Colorado's underserved by stressing the need to make community solutions. Caring for the medically indigent is too important to wait for the federal or state government to provide solutions. Instead the answer can and must be found one community at a time through the unifying mission of medical care.

Dr. Lewin served as Hawaii's Director of Health from 1986-1994. He was Hawaii's chief physician, chief environmental officer and CEO of the state's largest hospital system. Dr. Lewin resigned to run and ultimately lose a closely contested race for governor of Hawaii. He then established a consulting firm to help physicians succeed and regain legitimate authority in the rapidly changing health care environment.

In addition to the recognition he received during the Clinton Administration's efforts to revamp the health care system, Dr. Lewin earned the Arthur T. McCormack Award from the Association of State and Territorial Health Officers for excellence in public health. He was awarded the Justin Ford Kimball Award from the American Hospital Association for his ability to build consensus on health care issues. Last year the AMA presented him with the Nathan Davis Award as public physician of the year for his contributions to the prevention and treatment of HIV/AIDS and Hepatitis B. Dr. Lewin is now serving as the Executive Vice President/CEO of the California Medical Association.

Don't miss Dr. Lewin's address. For more information about *Caring for Colorado's Underserved* please see page 84.



Med Fax: Medico-Legal News

by Karen B. Best, Esq., an associate with the law firm of Montgomery Little & McGrew, P.C.

This column contains information concerning topics of general interest in the medical-legal field. For further information or help with specific problems, please contact Montgomery Little & McGrew, P.C.

Survey of 1996 BME Appellate Court Decisions

In 1996 the Colorado Court of Appeals issued several opinions reviewing disciplinary action taken by the Colorado Board of Medical Examiners against physicians. These opinions expand and clarify the definition of "medical practice" within the context of the Colorado Medical Practice Act (MPA), for purposes of imposing discipline on physicians. Under these opinions, a violation of generally accepted standards of practice with respect to either advertising or record-keeping can form the basis for disciplinary action under the MPA. The Court of Appeals also affirmed license revocation for a physician convicted of a felony in another state.

Misleading, Deceptive or False Advertising

Dr. T's practice was limited to the medical treatment of overweight and obese patients. He practiced exclusively in Texas for 20 years, where he owned and operated several weight loss clinics. Although he had been licensed to practice in Colorado since 1971, he never practiced here and had no plans to do so in the future.

In the early 1990's Dr. T placed advertisements in Texas newspapers promoting the use of Fluoxetine (Prozac) for weight loss. The ads stated "Fluoxetine Helps Overweight People Think of Food Less: Many overweight people are now being helped with both weight loss and maintenance of ideal weight with Fluoxetine...I have been so impressed by working with several hundred patients, that I now feel every overweight person should be given a trial for three weeks on this very safe medication. In many it will be a great help to complete the successful treatment of their overweight problem."

After Dr. T received a letter from the FDA questioning the content of the ads, he voluntarily withdrew them. A complaint also was filed against Dr. T with the Texas State BME prompted in part by these advertisements. Additionally, several patients filed complaints with the Texas Board regarding Dr. T's patient management. Dr. T resolved the Texas Board matter by accepting a public reprimand.

But his troubles weren't over yet. For starters, Dr. T failed to inform the Colorado BME of the adverse action taken in Texas. When the Colorado BME got word of the Texas order, it charged him with three violations of the Colorado Medical Practice Act, including failure to report the Texas order; acts of misleading, deceptive, and false advertising; and commission of two or more acts of substandard medical practice. After a hearing, the administrative law judge (ALJ) found that Dr. T had violated the MPA, and recommended his license be suspended for two years and that reinstatement be conditioned on completion of various continuing education requirements. Dr. T appealed.

Several of the Court's finding are worth mentioning: First, the ALJ is authorized to regulate the manner in which evidence is received at administrative hearings. In Dr. T's case, the ALJ properly allowed the prosecutor to take testimony by telephone.

Next, Dr. T argued that because his advertisements contained personal opinions rather than facts, they could not form the basis for a violation of the MPA. Wrong. The positive statements – that Prozac is a "very safe medication" and that "every overweight person should be given a trial for three weeks" – indicated not only opinion, but also definite knowledge or information regarding Prozac and weight loss.

Dr. T also argued there was no evidence he intended to mislead or deceive the public. Again, the Court disagreed. A physician can be found guilty of false, deceptive, or misleading advertising without having any intent whatsoever to mislead or deceive the public. If the "language of the advertisements evidenced an intent to communicate the information they contained," and the information in the advertisement itself is found to be false, deceptive, or misleading, the physician has violated the MPA, regardless of the physician's lack of intent to deceive.

Dr. T also argued that advertising is incidental to the practice of medicine, but is not the practice of medicine. The court again disagreed, concluding that Dr. T's advertising falls within the definition of the practice of medicine. Thus, it could be considered one of two acts which failed to meet generally accepted standards of medical practice, in violation of the Medical Practice Act.

Finally, Dr. T argued that the Colorado BME erred by imposing a punishment different from that imposed by the Texas Board when the conduct being considered in each disciplinary action was essentially the same.

(Continued next page)

Again, Dr. T is wrong. The Colorado Board is not bound by the discipline imposed by a board in any other state. As we see in this case, the punishment can be significantly more severe in Colorado.

Changing and Backdating the Medical Record

After the patient died, Dr. M allegedly changed a note in the patient's record, which estimated the patient's blood loss at 3,000 ccs, to read 2,000 ccs, by erasing the "3" and writing a "2" over it. The ALJ determined that erasing and writing over the entry was a violation of the MPA. Additionally, the Board determined that Dr. M added a staff note to the patient's medical record after the patient's death and backdated the note to the date of death. The Board found that backdating a medical records falls below generally accepted standards of medical practice. Having found two violations of the MPA, the Board issued a letter of admonition to Dr. M.

Dr. M argued that record-keeping does not constitute an acto of medical practice subject to regulation under the MPA. The Court of Appeals disagreed. The Act "is designed to give the Board the authority to regulate the overall practice of medicine, including the authority to impose discipline for record-keeping violations that violate the general standard of care."

In what seems a desperate position, Dr. M also argued that because the patient was dead when he altered the records, his conduct fell outside the practice of medicine. Wrong again.

Conviction of a Felony

Dr. B, an ophthalmologist, was convicted of wanton first degree assault, a felony in Kentucky, and sentenced to imprisonment for a maximum term of ten years. When the Colorado BME found out, it initiated disciplinary proceedings. In an interesting twist, Dr. B's Colorado license lapsed for nonpayment of license renewal fees before the Colorado attorney general lodged the formal complaint against Dr. B. Although he received adequate notice of the hearing, and was informed repeatedly of his rights, he did not participate either personally or through counsel. Ultimately the Board revoked his license.

Dr. B unsuccessfully argued on appeal that the Board lacked authority to act on his lapsed license. Under his theory the Board could only proceed with a hearing on charges against a "lapsed license" after the license applied for reinstatement of the license. The Court of Appeals disagreed finding that the Board is authorized to prefer charges against a physician whose license has lapsed and that such authority is not dependent upon the prior filing of an application for reinstatement. The Board can act in the public interest, and on its own initiative, even in the absence of injury or actual harmful effect on a medical practice.

Dr. B's due process rights were not violated due to the fact that he was incarcerated out of state during the hearing. "Due process requires only that the respondent have an *opportunity* to be heard. It does not mandate that the (physician), in fact, *be* heard if he or she does not choose to take advantage of this opportunity". Dr. B could have participated through counsel had he elected to do so; he could have submitted his position in writing; and he could have participated in the hearing by telephone. However, he did not avail himself of any of these opportunities.

The Board's order revoking Dr. B's license was affirmed.

Next month: A recent federal case which chips away at immunity for peer review participants.

As always, be careful out there. For more information, contact Montgomery, Little & McGrew, P.C.

Correction

The January edition of Medfax mistakenly reported that *Caring for Colorado's Underserved* forum would be held on March 7, 1997 at the Hilton Hotel Southeast. The forum will be held at the Holiday Inn Southeast in Denver.

CMS Med Fax

Colorado Medical Society provides the following listings of events as a member service only. Some events are approved for Continuing Medical Education credits. Information is provided by the sponsoring organizations. For more details, use the telephone contact at the end of the listing.

American College of Cardiology
Cardiovascular Conference at Snowbird
February 12-14, 1997
Snowbird, UT
1-800-253-4636 ext. 695

Colorado Society of Osteopathic Medicine
Ski & CME Midwinter Conference
February 23-28, 1997
Keystone Lodge & Resort, Colorado
CME Credits: 39 hours AOA Category 1-A CME crdt
Patricia Ellis (303) 322-1752 or 800-527-4578

American College of Cardiology
The 4th Annual Workshop on 2-D and Doppler Echocardiography at Vail
February 24-27, 1997
Vail, Colorado
1-800-253-4636 ext. 695

Colorado Dept. of Public Health & Environment
Managing Stress for STD/HIV Professionals
March 4, 1997
Denver, CO
Contact: Michael Murphy (303) 692-2766

Colorado Dept. of Public Health & Environment
HIV Prevention Counseling
March 12-13, 1997
Denver, CO
Contact: (303) 692-2740

American Lung Association
16th Annual Big Sky Pulmonary & Critical Care Med. Conf.
March 20-22, 1997
Big Sky, Montana
(406) 442-6556

The Prosper Meniere Society
6th Symposium and Workshops on Inner Ear Medicine and Surgery
March 22-29, 1997
Aspen, Colorado
Contact: Jane Wells, (303) 788-4235

Colorado Dept. of Public Health & Environment
HIV Prevention Counseling
April 16-17
Pueblo, CO
Contact: (303) 692-2740

Colorado Dept. of Public Health & Environment
HIV Prevention Counseling
May 14-15
Denver, CO
Contact: (303) 692-2740

Colorado Dept. of Public Health & Environment
Managing Stress for STD/HIV Professionals
June 3, 1997
Pueblo, CO
Contact: Michael Murphy (303) 692-2766

Colorado Society of Osteopathic Medicine
Annual Meeting
July 25-27, 1997
Vail, Colorado
18 hours AOA category 1-A CME and Physician Asst Crdt.
Contact: Patricia Ellis at (303) 322-1752

Send us your calender items.

If your specialty society or hospital is sponsoring a CME event or seminar which would be of interest to physicians in Colorado, have them send the information to: Event Calender, *Colorado Medicine*, P.O. Box 17550, Denver, CO 80217-0550. Please include information detailing program sponsor, date, location and phone number for more information.

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Executive Director's Update



Sandra L. Maloney
Executive Director
Colorado Medical Society

"Criminalize partial-birth abortions?"

That's what House Bill 97-1136, sponsored by Rep. Barry Arrington, would have you accept. The title reads: *"A bill for an act concerning the regulation of partial-birth abortions."*

And what does this term mean? By the description of the bill, the term "partial-birth abortion" means an abortion in which the person performing the abortion partially vaginally delivers a living fetus before killing the fetus and completing the delivery."

The theme this month of ***Colorado Medicine*** is "Telemedicine" which, in simple terms, is the use of more effective communications to improve medical practice, giving the patient every advantage of the latest technology. Here, the key phrase is "more effective communication". And that is something which is sorely needed in the fields of medicine and politics. HB 1136 certainly demonstrates this need. For instance, the bill "creates and defines the class 1 misdemeanor crime of criminal partial-birth abortion. Establishes an affirmative defense to a prosecution if the abortion was necessary to protect the life of the woman and no other medical procedure would suffice." Well, no one at Colorado Medical Society knows of any physician in the state who performs the type of abortion described here. We were also taken by surprise when this issue came up because no one recognized the term "partial-birth abortion". **There is no such medical procedure.**

What Colorado Medical Society has established as policy, and what certainly needed to be communicated to our legislators, is as follows:

"The termination of pregnancy by a licensed physician in an approved medical setting is a safe medical procedure surrounded by moral and ethical implications, and neither the State nor the Federal government should interfere with the physician/patient relationship and the ability of physicians to counsel their patients on all options for the management of an unwanted pregnancy unless there is compelling state interest in which case the regulations must be limited to those reasonably related to those interests.

The Colorado Medical Society strongly condemns any interference by the government or other third parties that causes a physician to compromise his or her medical judgment as to what information or treatment is in the best interest of the patient."

The same should be said concerning the proposed House Bill 97-1150, an attempt at criminalizing a medical procedure.

I believe this is all representative of a communications problem, and most of the fault is that of CMS in not getting its members to speak out more strongly to their legislators when these very same legislators are busy trying to redefine medical practice.

"Telemedicine, Legimedicine..." Let's talk!

It's the first of February, and the ***Sixty-First General Assembly*** is just under way. It's time for you to get busy. Become an active part of our government:

- **DON'T** leave it up to someone else or to the Medical Society.
- **DON'T** accept the legislators' redefinition of what medical treatment should mean to your patients.
- **DON'T** assume that because you are only one voice you will have no influence on your legislator.
- **DON'T** think that financial and political support alone will make everything go in favor of medical practice as it has been.
- **DO** find out who your representatives (Senate and House of Representatives) are at the Colorado State Capitol. Then make a concerted effort to voice your concerns and the concerns of your patients before these proposals become matter of fact.
- **DO** participate in CMS efforts to better communicate your feelings to the general public AND the General Assembly.

Above all, let's communicate.

- **DO let me hear from you!**

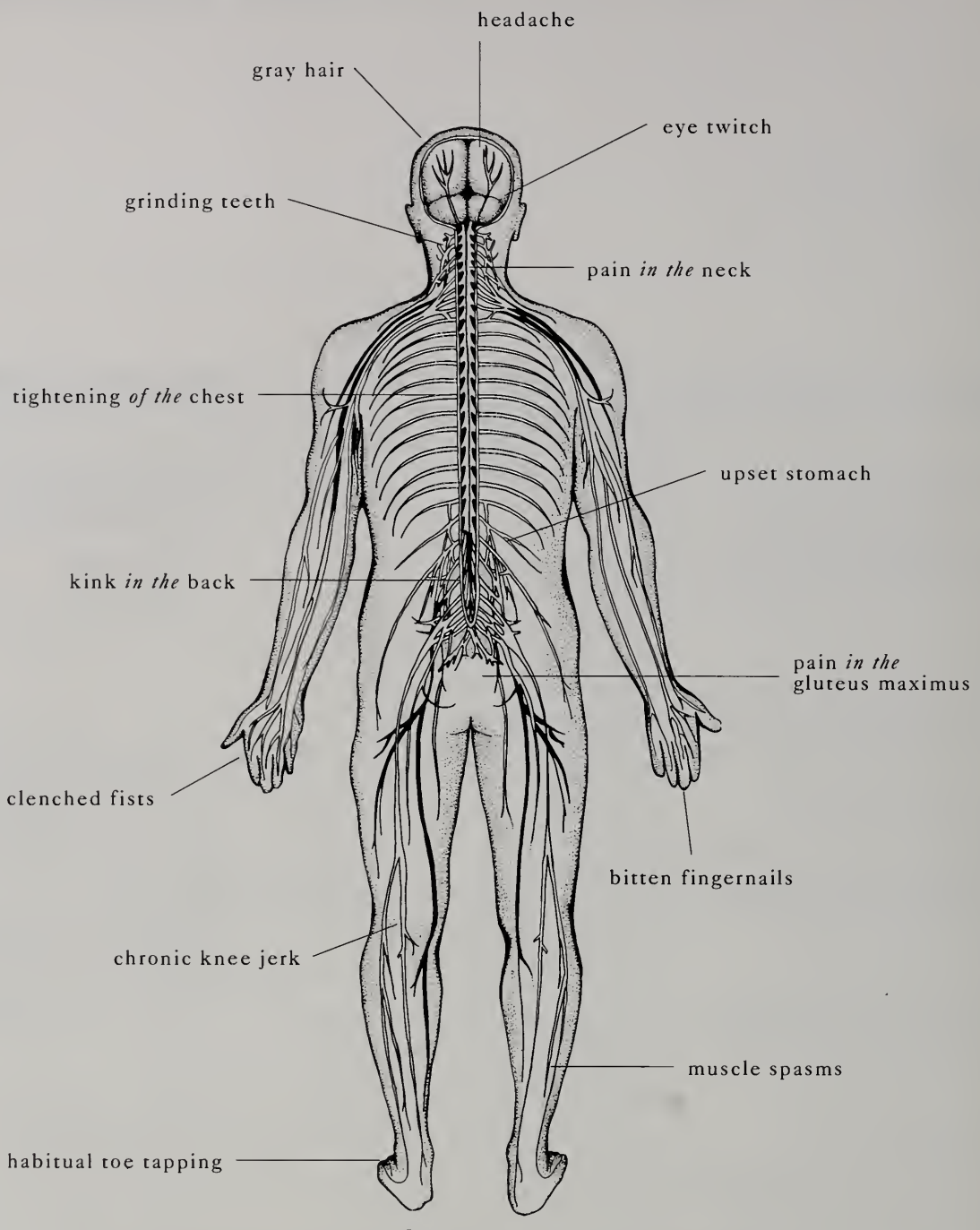


Figure 23

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The Lobby



by Richard Allen, MD
Co-chair CMS Council on Legislation

On January 8, the Legislature was officially convened with the usual festivities of speeches and the Governor's State of the State Address. Newly elected representatives and senators have been oriented and committee assignments have been made, but the real committee work did not start until the week of January 13. The clock on the 120 day calendar has started and there are some important deadlines to watch.

First of all, the bill introduction deadline is January 24 for Senate bills and January 29 for House bills. Thus, by the end of January virtually all bills will be available for review, except for a few late bills that will receive special consideration from the leadership. The next deadline will then be when the committees have to act on the bills by either getting them on the floor or to another committee, or they will have to postpone them indefinitely. This deadline for the Senate is February 7. The House deadline is one week later on February 14.

So far, there are 92 House bills and 54 Senate bills which we know about, but there will be dozens more introduced in the next few weeks. Legislators have asked whether the Colorado Medical Society is introducing any particular legislation. The answer to that question is that we are not, but we are very interested in the consumer protection issues under managed care. It is our understanding that there will be some bills introduced along those lines and we would be generally supportive of those concepts. Other rumors are that there will be a bill from the Trial Bar to increase the cap on non-economic damages as well as other medical malpractice changes to the Colorado Health Care Availability Act which passed in 1996. We will also have the usual bills from alternative providers looking to expand their scope of practice. We plan to carefully review legislation seeking to reform Medicaid in order to conform with the Kennedy-Kassebaum bill. The telemedicine issue will come forward again. House Bill (HB) 1050, sponsored by Rep. Epps and Sen. Wham, will attempt to establish some degree of control over out of state physicians influencing the practice of medicine in Colorado. Proponents of this legislation include members of the Colorado Radiologic Society.

Legislation on smoking, tobacco and infant hearing is also expected. Rep. Ken Gordon has a bill to monitor antibiotic prescribing. There are also a number of anti-abortion and parental rights bills.

The Council on Legislation met on January 15 to review some of this early legislation. Joan Hennibary of the Colorado State Department of Health and Environment presented information on a bill from the legislature to remove all funding from the state for family planning.

As you can see, the usual excitement and some of the usual issues will keep the Council and the Government Relations staff busy. We will make every effort to keep you informed. For up-to-date information please call the Government Relations staff at (303) 779-5455 or e-mail them to *gov_relations@cms.org.*

"Legislators have asked whether the Colorado Medical Society is introducing any particular legislation."

CMS Legislative Information on the Internet

Get up-to-the-minute legislative information on the CMS website. Point your web browser to: **http://www.cms.org**. Click on "CMS for Physicians" and then click on "Heard on the Hill." Summaries, status and calls to action regarding priority legislation which CMS is tracking can be reviewed online.

AMA Update



by ***Richert E. Quinn MD***
Senior Delegate to the AMA

The Interim Session of the AMA House of Delegates met in Atlanta December 7-11, 1996. As usual, there was no shortage of difficult and controversial issues to debate and for which to establish policy. I will attempt to briefly highlight what seemed to be the most important issues.

First of all, our Colorado delegation exerted enormous influence on the debate and policy considerations surrounding health care reform. Several years ago, CMS declined to endorse AMA policy concerning an employer mandate for health care coverage, feeling that the consequences for small employers would be devastating. Since then, our delegation has discussed this issue on many occasions arriving at a consensus that patient choice should be optimized. Voucher systems for employers providing coverage and equal tax deductibility for workers paying for their own coverage were some of the options discussed. One member of our delegation, Alternate Delegate and CMS Past President Joel Karlin, took these concepts and "ran" with them. He refined the concept of individually owned and individually selected health insurance and nurtured it through the CMS House of Delegates. He then did extensive research on existing AMA policy and proposed changes needed to implement these new concepts. By the time of the Interim Session, Joel had lined up thirteen other state delegations supporting Colorado's policy initiative. The Council on Medical Service and the Reference Committee also had to be won over. In the end, our initiative was adopted as new AMA policy in a largely intact form. During the House of Delegates Proceedings Stormy Johnson, the current AMA President interrupted debate to pay tribute to Joel Karlin for guiding these initiatives through the House. Needless to say, our tiny three-seat delegation was very proud.

The AMAP (American Medical Accreditation Program), initiated in recent months by the AMA Board, was debated extensively with a "go slow" attitude being recommended by some specialty societies. However, it was felt that the program might fall irretrievably behind non-physician controlled credentialing and accrediting entities if development is delayed. Certainly, the entire Federation of Medicine is to be included in these efforts and state and county efforts are to be incorporated, not usurped. With appropriate oversight, the effort to implement the AMAP program is to continue.

The issue of mandatory testing of pregnant women for HIV again surfaced at this meeting. Colorado submitted a resolution allowing for choice but with mandated counseling. The House reaffirmed its vote of Six months ago, calling for mandatory testing. The House also adopted a resolution calling for mandatory information and counseling for pregnant women.

Termination of late term pregnancies was a very volatile and emotional topic of discussion. In the end the issue was to be studied by the AMA Board, councils and pertinent specialty societies in terms of what should constitute "standards of good medical practice", in addition to developing appropriate clinical practice guidelines for late term pregnancy termination.

There is concern about the funding of graduate medical education in the future, given the widely-held perception that physicians are being trained beyond national requirements. This training is primarily funded by the government at the present time. The House of Delegates voted to support an "all payer" system of support along with seven other recommendations, including the establishment of an authorization system yet to be specified (for example, a voucher system) to provide funding for the training program at the site where the training occurs. An open hearing concerning physician workforce development was attended by one thousand physicians and representatives of all the major stakeholders including academia, government and organized medicine.

The AMA continues to strongly oppose physician-assisted suicide. This issue is to be heard by the Supreme Court of the United States this year and the AMA has filed and extensive amicus brief with the Court.

Our Colorado delegation continues to make its influence felt at AMA meetings. The CMS staff support is gratifying. We think we are representing our members to the best of our abilities and appreciate the support of CMS members and its Board of Directors.

Here's Our Agenda

It's simple. It's straightforward. And it represents the future of medicine. The American Medical Association presented to the Republican and Democratic leadership this agenda for the upcoming 105th Congress. Your AMA membership strengthens our voice in support of physicians and their patients. . . and will enhance our efforts to turn these goals into reality.

- **Patient Protections** Above all, preserve the ability of physicians to act as advocates for their individual patients. Do not allow insurers to "gag" physicians or withhold medically necessary treatments from their patients.

- **Medicare Reform** Make the Medicare program solvent. Expand patient choice of plans. Allow future growth rates that cover patients needs. Retain special protection for the vulnerable and elderly.

- **Medical Education and Research** Continue to support medical education and research so we can find cures for killers such as AIDS and cancer.

- **Public Health Problems** Expand prevention and treatment programs to combat AIDS, drug abuse, smoking and violence. These problems cost billions of dollars and millions of lives.

- **Liability Reform** Enact meaningful liability reform to ensure fair compensation to patients with legitimate claims while eliminating excessive malpractice awards that lead to defensive medicine.

Join or renew your membership in the AMA today — call 800 AMA-3211

American Medical Association

Physicians dedicated to the health of America

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A Physician's Affirmation

"In order to be worthy of self-respect I pledge to give the respect due others in a free society who place their trust in me as a professional in the healing arts. Therefore:

I will practice my art and my science to benefit my patients.

I will disclose to my patients that which I know of their disease, and any hazards of the remedies I might suggest, that I may guide them to choose the course that suits them best.

I will offer care and comfort when they are ill, and when death becomes inevitable, I will ease their way as best I can in keeping with their expressed plan.

I will recognize their right to self-determination and if conflict should arise with my own ethical constraints, make them aware without judging wherein we differ that they may consider seeking help elsewhere for their complaints.

I will intercede in their behalf within the scope of my authority if I perceive they are being treated without regard for their humanity.

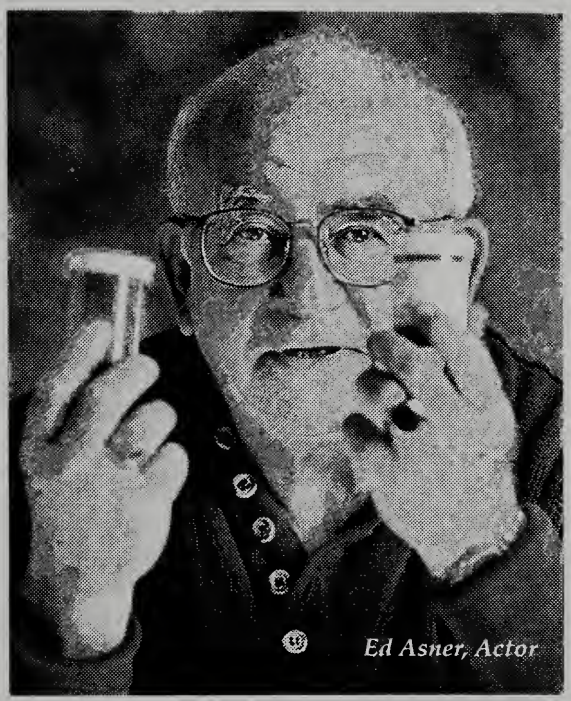
I will hold in confidence that which is seen or heard in my role as physician.

I will ever be a student to sharpen my skills and knowledge to make me a better clinician.

If I act in this way I may aspire to join the men and women through the ages who approach the loftiest ideals of the healing mission, for I will have earned the faith and trust which is the strongest tie in the bond between patient and physician."

Fredrick Ralph Abrams, M.D.

Attention: Physicians



Have your patients' medicines had a check-up?

Many of your patients take several different medicines every day. Separately each one works well. But if they take two or more different medicines in combination without checking with you to be sure they work safely together, they can sometimes be harmful...even dangerous.

The next time you prescribe a medicine, ask your patients:

"What other prescription and nonprescription medicines are you taking?"

A public service message from the National Council on Patient Information and Education (NCPIE) and the U.S. Administration on Aging

Write for *free information* on patient medicine counseling.

OR FAX: (202)638-0773

Mail to:

NCPIE
666 Eleventh Street, NW
Suite 810
Washington, DC 20001

Copic Comment

by Jerome M. Buckley, MD
Chairman & CEO
Copic Insurance Company



Copic charts its course for 1997

Copic will hold its annual meeting the last weekend of February; following that meeting, I will report regarding our 1996 performance. However, as we begin 1997, I think it is appropriate that we look to the year ahead with anticipation.

Copic's Board will undergo a transformation in 1997. We said good-bye in 1996 to Fred Lewis, a founding Board member who passed away in June. In addition, two other founding Board members -- Amilu Rothhammer, M.D., and Merlin G. Otteman, M.D. -- moved to Emeritus status as of December 31, 1996. They will, however, be readily available to us for the next two years in an advisory capacity. Following in their august footsteps are three new Board members: Barbara Reed, M.D., a dermatologist from Denver; Jack Berry, M.D., a family practitioner from Wray; and John Wolz, M.D., a general surgeon from Ft. Morgan.

Our major concern in the legislative arena for 1997 will be to protect the tort reform for which we fought so passionately. I sincerely believe that Colorado has the best overall tort reform package in the nation, even exceeding the highly touted MICRA in California. Recently, Copic designed model collaborative agreements for working with advanced nurse practitioners as a result of such legislation in 1996, and 1997 will give us the opportunity to test our collaborative risk management principles.

With continued consolidation in the health care arena, Copic will continue to find ways to provide products and services that address hospitals, physicians, managed care organizations and medical entities in a seamless manner. The consolidation among physicians will require us to provide competitive but highly monitored programs that consider group size, experience rating, and special group-specific risk management programs -- especially those utilizing computer/electronic systems, tickler files, medical records and medication monitoring/interaction programs (such as the new MediSource).

We intend to address physician needs regarding credentialing and office assessment services by "bundling" Gadrian and Practice Quality, our new NCQA (National Committee for Quality Assurance) office assessment program. We will be working to achieve a situation in which Colorado physicians only have to deal with the true minimum number of applications (the ideal -- and our goal -- is one) and renewals (we presently can't get NCQA to less than three due to their 120 day "fresh data" rule).

Personal needs such as long-term medical disability and long term care will also figure prominently in Copic's 1997 plans. We continue to look for relationships with our sister PIAA companies to address the issues raised by practice across state lines and by national chain challenges. Copic Agency's ability to assist physicians will be further explored and clearly expanded in 1997. As specific programs become formalized, details will be provided.

Last year was a challenge successfully met, but 1997 looks even more exciting! We will keep you informed.

Remember:

Your membership in COMPAC will assist with financing the campaign of legislators who are supportive of medical practice issues. 1997 is already a critical legislative year to medicine, so help however you can.

COMPAC



by John Lightburn, MD
Historian
Colorado Medical Society

Two "firsts" in the land of shadows

by Seymour E. Wheelock, MD
Chairman Emeritus
Dept. of Ambulatory Pediatrics
Children's Hospital, Denver

It is a gray November, 1895. Conrad Roentgen and his wife stare at a plate of sensitized material "Look, Hendrika," he says quietly. "These are your rings and the bones of your hand! We may have something here."

Later on, Roentgen: dedicated, humble and reticent, will give one, and only one, public presentation on "The New Light." For his world-transforming discovery he will receive the Nobel Prize--50,000 kroners--and donate it all to his university for research in physics.

It is Monday, the third of February, 1896, and a disdainful and unrewarding winter's sun is already nearly out of view behind the steel blue Vermont hills. Eddie McCarthy, age 8, is skating across the frozen Connecticut River on his way home. The steel runner of his homemade wooden skates strikes a small log invisible in the ice and he goes down, right arm outstretched to break his fall.

His physician, Dr. Gilman Frost of Hanover, New Hampshire, seeing the angulation of the arm and keenly aware of some experiments he, his brother, Edwin Frost, a professor of Astronomy, and two members of the Dartmouth College Department of Physics had only two days before performed, hustles the groaning Eddie over to the physics apparatus room. Using a departmental Crookes tube, and with a high sense of history, he takes the first clinical x-ray to be done in the United States. The first diagnostic impression is to the point: "Both bones are busted".

It is some time in the mellow spring of 1896 in Denver. Young James Smith, an impecunious and awkward law student places a ladder against a cottonwood branch damaged in a recent heavy snowstorm. The ladder slips on the wet bark and James crashes to the ground, landing on his hip and thigh.

Wreathed in pain, he consults an eminent surgeon, Dr. W. W. Grant, one of the founders of the American College of Surgeons, and known in far distant places as the first to do an appendectomy in the United States, among other venturesome procedures. Dr. Grant thinks it unnecessary to immobilize the thigh and provides avuncular advice. "It is", he states, "merely bruised muscles. Hot baths, my lad, hot baths and arnica three times a day, plus moderate exercise. That will be two dollars. Good day."

But James, who cannot sleep or walk without pain, finally seeks advice elsewhere. The consultant with pursed lips and a raised eyebrow, declares "Son, you may well have a fractured hip bone; bruised muscles should have healed by now". So James, on April 14, 1896, brings suit and selects for his lawyers Fred W. Parks and his associate, a young attorney in his early '20s, Ben B. Lindsey. (Denver will come to know Lindsey as founder of the Denver Juvenile Court.)

The opposition was formidable. Lindsey later recalled with obvious delight the difficulties the plaintiff faced and the unique status of the x-rays. But let him tell it:

"Parks was active in politics and then one of the youngest State Senators that ever sat in the capital. Lindsey - still under thirty - shortly afterwards became judge of what is now the Juvenile and Family Court of Denver. The attorneys for Dr. Grant were the late U.S. Senator Charles J. Hughes, Caldwell Yeaman and State Senator Frank Gove. Mr. Hughes was considered the most brilliant lawyer that Denver ever had; Messrs. Yeaman and Gove were among Denver's most distinguished lawyers; these eminent lawyers had with them for the defense, the most eminent surgeons in Denver, among them, Dr. L. E. Lemen, chief surgeon for Union Pacific Railroad and, I believe, one of the big smelter

Author's Note:

In this issue I have invited a "guest historian" to take us back one-hundred years to a first use of x-ray in evidence for a medical malpractice suit.

Seymour E. Wheelock, M.D., prominent Denver pediatrician, is our guest historian . His historical vignette first appeared in the Children's Hospital newsletter.

John Lightburn, MD

companies; Dr. O'Conner, chief surgeon for one of the big railroad companies. It was impossible for Smith's attorneys to get any physicians of similar eminence and standing to consent to testify, although several of them told me confidentially that there was not the slightest doubt in their minds about the case being one of fracture and not of bruised muscle.

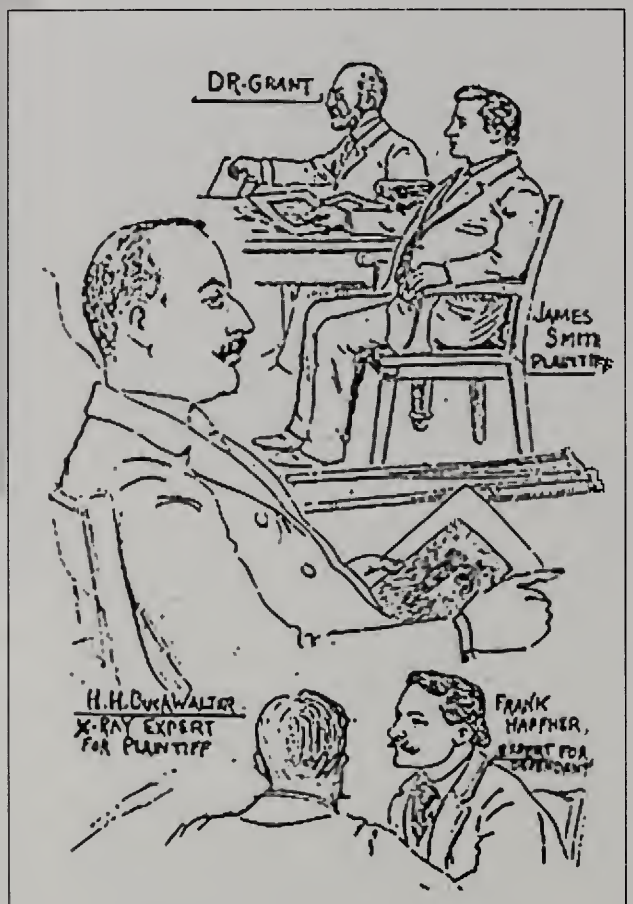
I knew that our case depended largely on proving that it was a fracture and with that fact established, that our case became much more complete. The controversy raged over this question. It was a short time before the first trial that I had read something in the papers about Dr. Roentgen (I think it was) and his experiments with the Crook's tube and the X-ray. I found in Denver that one young man had been experimenting with the Crook's tube and one photographer who were attempting similar experiments. The young men in question were Dr. Tennant and a photographer named H. H. Buckwalter."

So the uncomfortable Mr. Smith and his lawyers went off to the Denver Homeopathic College where Dr. C. E. Tennant and Mr. Harry H. Buckwalter were spraying electrons and photons around their laboratory "for their own amusement and that of their friends". About the same time, however, the two had taken plates of Central City Marshall Kelher who had been shot in the mediastinum during a barroom brawl, so they were ready.

On November 7, 11, 21, and 28, 1896, plates were taken of Smith's femur utilizing a fearfully long exposure of eighty minutes or so and clearly revealing that "the head of the bone was not in normal relation to the great trochanter and shaft".

Lindsey and Parks then proposed that these "shadow pictures" or "Roentgen pictures" be submitted to the jury as evidence of fracture. "The electrical apparatus, batteries and Crookes' tube were all in the court-room," Lindsey recalled. "We offered to show the jury the bones in their hands, which created such terrific excitement about the courthouse that extra bailiffs were called in to keep the court in order during the argument. The excitement was intense."

On Thursday, December 2, 1896, with Judge Owen LeFevre presiding, case number 24,159 came to trial. The defense argued for three hours against the admission of "X-ray photographs" as evidence. Charles J. Hughes pontificated that the x-ray would never be anything but a toy and that "there is no way to prove that such a thing can be done and even if it were done it can not be depended upon as showing anything in the interior of the human body."



Artist's sketch of the court room scene.—

Judge LeFevre listened with deep concentration, looked at the plates, ran his hands over the Crookes' tube and announced that he would sleep on it with the intent to announce his decision in the morning. "Court adjourned!"

On December 3rd before a standing-room-only crowd, the Judge delivered his written, and historic, opinion. The last paragraph reads:

"During the last decade, at least, no science has made such mighty strides forward as surgery. It is eminently a scientific profession, alike interesting to the learned and unlearned. It makes use of all science and learning. It has been of inestimable service to mankind. It must not be said of the law that it is wedded to precedent; that it will not lend a helping hand. Rather, let the courts throw open the door to all well considered scientific discoveries. Modern science has made it possible to look beneath the tissues of the human body, and has aided surgery in telling of the hidden mysteries. We believe it to be our duty in this case to be the first, if you please to so consider it, in admitting in evidence a process known and acknowledged as a determinant science. *The exhibits will be admitted in evidence."*

So it was: an x-ray was accepted into the ponderous machinery of a court of law for the very first time in the legal history of the United States and the names of the two obscure young people would have made it into the *"Guiness Book of World Records®"*, had there been such a book.

Postscript: There were two trials, both ending in hung juries. Before a third trial came to court some of Dr. Grant's friends made a settlement satisfactory to the plaintiff, and that ended the litigation.

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Physician Self-Perceived Risk Behaviors and Communication

by Kathy Gardner, BSN, Ph.D
Assistant Vice President
Copic Insurance Company



"The purpose of this research study was to examine physician self-perceived communication behaviors and to investigate where a relationship existed between that behavior and medical malpractice experience."

Author's note:

I am indebted to the Colorado physicians who participated in the pilot study and those in the final research sample.

My sincere thanks to each of you.

The therapeutic power of the physician-patient relationship has been noted since the time of the ancient Greeks (Roter, Hall and Katz, 1988). Only in the last 25 years or so have the actual dynamics of the therapeutic dialogue been observed in a consistent manner. The evolution of improved methodology and sophisticated technology, such as interactions using simulated patients, videotape and immediate feedback, has made empirical observation of physician-patient encounters easier to achieve.

Central to a debate in the literature about the ideal physician-patient relationship has been the need to define the function of the encounter, and role clarifications in the medical decision-making process. Emanuel and Emanuel (1992) argued that this debate is characterized by a conflict between autonomy and health or between the values of the physician and the values of the patient. Physician-patient expectations, ethical issues, legal standards for the physician, and medical malpractice exposure are a few of the considerations that Emanuel and Emanuel believe must be evaluated to define the ideal relationship.

Much of the previous research has investigated the physician-patient relationship from the patient's perspective. The present study examined the relationship from the physician's perspective.

The communication of information is widely regarded as the single most common form of interaction during routine medical visits (Roter, 1983). Empirical research supports the position that patients highly value information. Poor communication, the literature suggests, is the single most common source of patient dissatisfaction with physician care (Waitzkin, H., and Stoeckle, J., 1972; Ware, J. and Snyder, M., 1975; Roter, 1977).

L. M. Ong (1995) asserts that there are three central purposes for communication between physicians and patients. The interaction focuses on information-giving, information-seeking, and decision-making. The physician needs information in order to establish the correct diagnosis and to design a treatment plan. The patient needs to know and understand what is actually happening to him or her. The physician and patient communicate in order to give and to seek information alternately.

An article in Applied Communication Research by Sheer, V.C. and Cline, R.J. (1995) has called for specific research concerning the physician-patient relationship which is consistent with this research project. These researchers have written that past research "neglects the physician's perspective on the medical encounter" (p. 56). This

research study probed the physician's risk management self-perceived communication behavior during the physician-patient encounter and is intended to add to the body of knowledge on this subject.

Complications of treatment and less than ideal outcomes do occur throughout medicine. Only a small proportion of these events result in the filing of a suit for malpractice by a patient or a patient's family. A significant proportion of these suits can be seen as an expression of a serious breakdown in the physician-patient relationship.

A number of factors other than negligence can contribute to the initiation of a malpractice action against a physician. In order to understand this phenomenon, this study investigated what researchers have found to be specific factors contributing to the occurrence, characteristics of sued and nonsued physicians, reactions to being sued, educational processes (risk management) aimed at avoiding suits and limiting losses, and practice changes that occur as a result of a lawsuit.

Assessing patient satisfaction as a predictor for the potential of experiencing malpractice claims, Hickson et al. (1994) found that the frequency with which physicians are sued is related in part to whether the patients are satisfied with the interpersonal aspects of their medical care. They found that physicians who had never been sued were more likely to be seen by their patients as being concerned, accessible, and willing to communicate with them. At the other extreme, Hickson et al. (1994) noted that physicians who had been sued frequently, were seen as hurried, uninterested and unwilling to listen and answer questions. These researchers concluded that many physicians who are sued have problems communicating and establishing rapport with their patients.

Charles, S.C., Wilbert, J., and Franke, K.T., (1985) identified nine personal and professional characteristics among a range of quality of care indicators that were associated with a physician's tendency towards high or low risks for claims. They found that high risk was associated with factors such as increased age, surgical specialty, emergency room coverage, increased number of days away from practice, and a perceived feeling that the climate of litigations was "unfair." Low risk was associated with scheduling sufficient time to communicate with patients, answering patients' telephone calls directly, feeling "satisfied" with practice arrangements, and acknowledging a greater degree of current emotional stress.

Investigators have theorized that poor communication between physicians and their patients may be a major contributing factor as to why a patient decides to initiate a lawsuit. Adamson et al. (1989), maintain that a relationship between claims and communication skills has not been assessed directly. There are several sources of evidence that suggest such a relationship does exist. The most frequent reasons cited for malpractice action were patients' unhappiness with their underlying disease process and a lack of communication by the physician.

The purpose of this research study was to examine physician self-perceived communication behaviors and to investigate where a relationship existed between that behavior and medical malpractice experience. This research study focused on two groups of physicians practicing in Colorado and insured with a large professional liability insurance company. These were groups of physicians who had been sued and those who had not experienced a medical malpractice suit. The randomly chosen samples used in this study were two surgical and two medical specialties practicing between 1989 and 1994.

The investigation examined the relational aspects of the physician-patient interactions using risk management axioms to determine if there were significant differences within and between these groups. The two theoretical concerns under investigation were: Does a relationship exist between the physician's self-perceived communication behavior and medical liability exposure? Is there a relationship between practice location, specialty, gender and past malpractice experience?

Physicians have a responsibility within the medical encounter for the management of their relationship with their patients (Green, 1988). This responsibility involves the development of an awareness, through effective communication, of those influences suggested by researchers that can improve the relationship and insure greater satisfactions for both parties in the encounter. Dance, F. E.X., (1970) called for medical educators to teach the art of interpersonal communication and listening skills; Brittain, Robert, (1984) recommended increased awareness of why patients became litigious; Roter et al. (1988, 1991, 1992) suggested open discussions during the encounter, the awareness of the importance of verbal and nonverbal behaviors, and the importance of the content and context of the information exchange process. Mishler (1984) and Ong (1995) argued for the use of effective communication language to enhance patient understanding and the reduction of uncertainty. The ultimate aim for future research should be to develop teaching modalities to heighten awareness by the physician of all these factors, and to realize Roter's ideal (Roter, D.S., 1983) of a common responsibility, shared by physician and patient, for the two-way exchange of information. Improved communication and enhanced mutual satisfaction for physicians and patients in this complex relationship may be achieved.

Since no appropriate instrument was found in the literature to measure the self- perceived communication behavior of physicians, a self-report questionnaire was developed by the principle investigator. The 30 statement instrument, using five point Likert scales, focused on communication and risk management related behaviors. An explana-

(Continued)

tion was given at the beginning of the questionnaire informing the physician that there were no right or wrong answers to the statements.

Respondents were asked to indicate whether their self-perceived behavior was "almost always true," "often true," "sometimes true," "seldom true," or "almost never true."

The questionnaire contained statements covering five primary aspects of the physician-patient encounter identified by researchers (Lipkin, M., Franke, R.M., Beckman, H.B., Charon, R. and Fein, D., 1995; Kreps, G.L. and Thornton, B.C., 1992). There were:

- Initiating the encounter
- Exchanging information
- Providing emotional support
- Establishing a collaborative relationship
- Closing the encounter.

Two primary groups of physicians were assessed: physicians who have been sued and those who have not been sued. The randomly chosen sample consisted of 400 (r=247) actively practicing physicians insured in Colorado between 1989 and 1994 and they were members of the Colorado Medical Society. Four specialties were chosen. Family Practice and Internal Medicine - low risk, and Orthopaedics and General Surgery - high risk.

The research question under consideration was whether there were significant differences among physicians' self-reported communication behaviors based on practice location, specialty, gender or past malpractice experience.

The factor analysis of the questionnaire instrument yielded three factors: Factor I - Information Exchange, Factor II - Compliance-gaining, and Factor III - Immediacy.

The first factor was found to be the strongest, with an eigenvalue of 5.47. This was three times the size of the next largest eigenvalue (1.87). The overall mean scores within this factor were also found to be strongest.

These findings suggest that the first factor was perceived as important overall for physicians in this sample group and is a primary concern during the physician-patient encounter. This is similar to the findings of Roter (1983), who reported that the communication of information is widely regarded as the single most common form of interaction during routine medical visits. Empirical research by Waitzkin and Stoeckle (1976); Ware and Snyder (1975); and Roter, et al. (1988) support the position that patients highly value information. These researchers maintain that poor communication is the single most common source of patient dissatisfaction with medical care.

Factor II - Compliance-gaining was found to be the second most important process when physicians interact with patients during the medical encounter.

Roter and Hall (1993) have estimated that patients' noncompliance rates range from 30% to 60%. These researchers maintain that physicians frequently suspect that their patients are not adhering to prescribed recommendations, patients tend not to volunteer the information, and physicians may not seek confirmation of this possibility. The mean scores within Factor II - Compliance-gaining in the present research suggest that this sample group was concerned with providing adequate verbal and nonverbal information to reduce uncertainty and enhance patient compliance.

The third factor found as a result of the factor analysis was Immediacy (eye contact, body lean, proxemics). Respondents indicated that communication behaviors associated with immediacy could have importance during the physician-patient encounter.

Thirteen significant findings were reported as a result of the MANOVA main effect analyses. For the total sample of sued physicians, there was a low negative correlation for the use of open-ended questions. The implication of this finding was that open-ended questions are not used by sued physicians in this sample. Other findings were: General Surgeons did not summarize information for the patient; did focus on the patient and explained the physical examination; and discussed alternatives, risks and benefits of procedures. Orthopedists discussed alternatives, risks and benefits of procedures; told impressions; asked patients about expectations; and male physicians in this specialty investigated patients' beliefs.

Internal Medicine physicians had one significant finding. The not sued Internists perceived their behavior as focusing on the patient during the encounter.

The specialty of Family Practice demonstrated the highest number of significant findings in this study. Female Family Practice physicians reported seeking patients' agreement, investigated patients' expectations and beliefs, provided written instructions, sought opportunities to calm the patient, and used open-ended questions. The overall significant findings in this specialty indicated that family practice physicians perceived that they asked patients about expectations and explained the physical exam when performing that procedure.

This research suggests that female physicians overall are using more risk prevention communication behaviors that may assist them in decreasing their malpractice exposure than are their male counterparts across all four specialties in this research study.

Editor's Note:

For a complete copy of Dr. Gardner's research project, contact the Copic Insurance Company Risk Management Office, (303) 779-0044, or 1-800-421-1834, Ext. 2437.

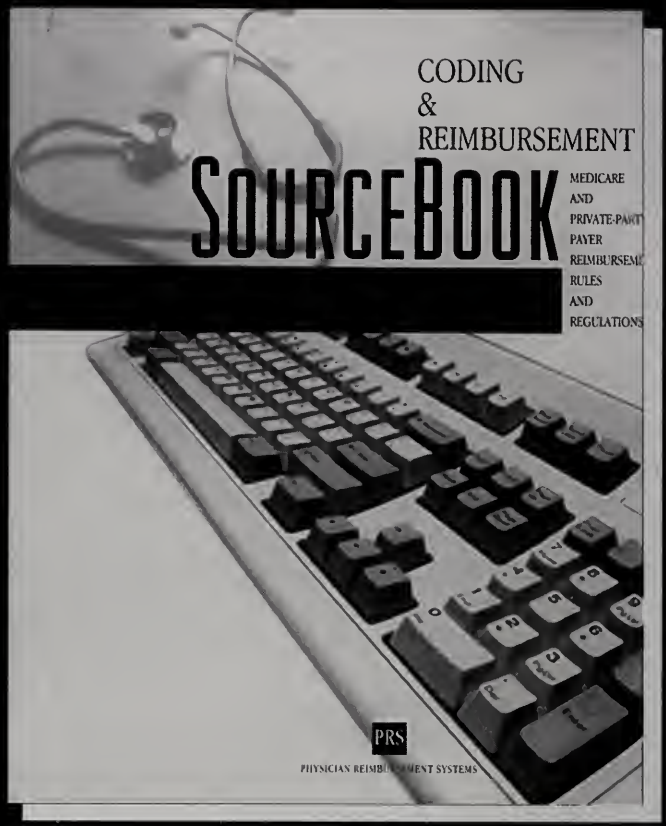
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Updated three times a year, the *SourceBook* is available to CMS members for the discounted price of $132. Compare this discount to the non-member rate of $184, plus $15 shipping and handling!

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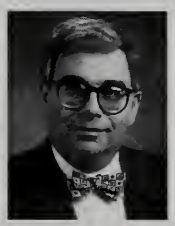
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School of Medicine on the Right Course



by Richard D. Krugman, MD, Dean
University of Colorado School of Medicine

The fact that our current first-year medical students comprise the Class of 2000 has a startling ring to it, reminding us that the swiftness of the passing years is leading us, inexorably, not only toward a new century but a whole new world of medicine.

What these young men and women will face as they walk into that world cannot be accurately predicted at this time. One thing is certain, however: We need to provide them with a solid foundation through good medical education, and with steadfastness, values, and resilience--so that they can be good doctors in the 21st century.

To do this, a strong and on-course medical school is a necessity.

So, I am pleased to provide, despite the foibles of the marketplace, a positive status report corning the status of the University of Colorado School of Medicine:

- The Class of 2000 is 48 percent women, the highest in 23 years.
- A total of 368 preceptors, 60 percent of whom are in private practice, now are involved in the Primary Care I, II, and III course. This means that more and more of you are joining in the development of these new physicians, and I cannot imagine a more important and productive contribution for you to make.
- Fifty-seven percent of the Class of 1996 chose primary care residencies.
- Our school's Academic Achievement Fund, created by a 10 percent "tax" on all faculty clinical revenue to support the school is healthy.
- The overall education of house staff is viewed as above average by exiting house staff.
- Both clinical and research revenues continue their remarkable growths. In grant income from the National Institutes of Health, CU was eighth among public schools of medicine, 19th overall, and fifth in rate of growth compared to peers. Less than eight percent of the school's total revenues, it should be noted, come from state tax sources. This has led to an increase in faculty size.

It isn't all good news. In spite of efforts to increase the numbers of applicants to our programs, we are still significantly under-represented in African American, Native American and Hispanic residents. One hopes we can do better in this arena. Also, it must be noted that the average debt load of our graduating students is currently $67,739!

With regard to facilities, we remain critically short of educational space. The new education building, which is Phase 1 of the Campus Center project, is underway and should alleviate much of that problem. This building will be constructed irrespective of the eventual relocation of some of our programs to Fitzsimmons.

Finally, the following is a quick summary of achievements in the four primary missions of the School of Medicine:

We've made governance changes in the educational enterprise to ensure that the education of physicians is much more than just the sum total of all of our course offerings, and to secure continuity across the four years' experience.

In the research arena, two retreats have been productive, covering topics from structure of the Graduate School to laboratory facilities needs. These, I believe, were quite productive and helpful in laying out options for the future.

With regard to clinical care, tumult has characterized the year throughout U.S. academic health centers, schools of medicine and university hospitals. The carnage of now former deans, chancellors and hospital presidents throughout the country is a testimonial to the difficulties presented by the marketplace.

Is our clinical enterprise a marketable commodity or a vital organ? I believe it is the latter. We cannot segregate education and research on one hand from clinical service on the other. We will not be true to our mission of we leave to any insurance company, managed care plan or hospital administrator the responsibility for carrying out the clinical part of our mission.

The School's budget is strong. We continue to wait for the inevitable turn down in revenue but it has yet to happen. I think it will, but believe we are well prepared for it.

I trust that this faculty and our colleagues in the community will continue to keep this school strong. We need to continually improve, but I think we are on the right course.

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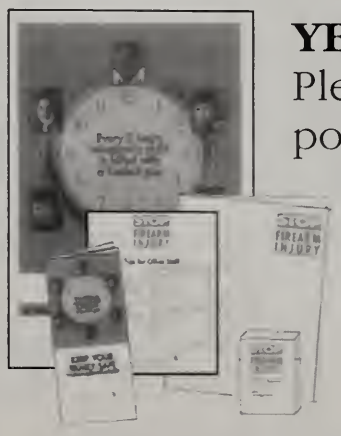
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Colorado Physician Network, Inc.



David C. Martz, MD
President
Colorado Physician Network

On Saturday, January 2, 1997, the Denver Broncos "snatched defeat from the jaws of victory." Entering the playoffs following their best season ever, having secured home field advantage earlier than any NFL team in history, they were certain to advance to the AFC Championship game and likely to be in Superbowl XXI. They had every reason to believe that they should and would succeed in making it to at least the Final Four out of a field of 30 competitors.

Except for one thing: they didn't execute when it counted. Whether they altered from over-confidence, under-preparation, bad breaks, poor focus, marginal performance or superior competition, they failed to achieve that to which they believed themselves entitled.

As we filed out of Mile High Stadium and headed home, I found myself reliving the Broncos season and the prematurely final game, and wondering what symbolism for Rocky Mountain Physicians' Choice lay in the NFL playoffs.

What team would be our model: the hometown favorites, who let it slip through their grasp; the upstart "Cinderella" Jaguars, who exceeded everyone's expectations by refusing to be discounted; the Green Bay Packers, who had known dominance historically and now reclaimed their former power with the support of the com munity they served?

And how will we perform, now that implementation is upon us? We have prepared vigorously for this time; we have the right tools, the right values, and the right motivation. We have capable leadership, a tradition of excellence, and the potential of unifying teamwork. There is a supportive and receptive audience, eager to enjoy the benefits of our efforts.

Clearly no one will GIVE us success, though we--like the Broncos--may feel entitled to it. It is rather OUR responsibility to press forward now as never before, believing in what we represent and committed to make it happen this year. Let us focus on our strengths, enhance our limitations, unify our ranks, and press forward with confidence as we bring to Coloradans that which they have cherished and deserved: the first Super HMO--Rocky Mountain Physicians' Choice.... a Winner!

Doctor:

Please complete the important financial services survey on the following pages.

Don't let them Suffer In Silence!

For resource materials and patient information, contact: Ellen Stein at the CMS offices at 779-5455 or 1-800-654-5653 or E-mail *Ellen_Stein@cms.org*.

There are so many things you, the physician, can do to help people in distress and whose lives are actually endangered. Carry the calendar (included in this issue) to remind you and your associates of what needs to be done to save lives.

Don't hesitate a minute longer. Call us today!

Important Financial Services Survey

In January the HWC Group/Merrill Lynch will offer financial services to Colorado Medical Society members. This new financial program features an educational program based on the financial information needs of the membership. The survey below is a crucial element in determining those needs. It is not intended to elicit personal information, nor is it intended to sell any services of the HWC Group or Merrill Lynch. Your responses will assist in formulating seminars and educational programs that will best serve the wishes of the entire membership. Strict confidentiality will be observed. Please answer the questions below and then mail the survey to: **Colorado Medical Society, P.O. Box 17550, Denver, CO 80217-0550, Attn: Member Services.**

1. How has managed health care affected your practice? (Grade one through five, one being the least positive)
   - A. Positively ____
   - B. Negatively ____
   - C. Not felt much either way ____

2. Please identify your preferred method of communication. (Grade one through five, one being the least positive)
   - A. Mail _____
   - B. Telephone _____
   - C. FAX _____
   - D. E-mail/Bulletin board _____
   - E. Media _____
   - F. Seminars _____
   - G. Internet _____

3. Can you suggest ways in which improved communications and information handling by Colorado Medical Society can aid you in your medical practice? **Yes** ____ **No** ____

   A. If you answered YES, please comment: _____

   _____

   _____

   _____

   _____

4. If you have access to the Internet, do you think that it can be used in a manner that could assist you in your practice? **Yes** ____ **No** ____

   A. If you answered YES, please explain: _____

   _____

   _____

5. Do you currently use E-mail? **Yes** ____ **No** ____

   A. If you answered YES, how could E-mail be used to exchange information between you, CMS and HWC Group/Merrill Lynch? _____

   _____

   _____

(over)

(CMS/HWC Group Survey continued)

6. How would you rank your needs for financial services? (1 not much – 5 very much)
   - A. Mortgage or financing services _____
   - B. Trust services _____
   - C. Estate planning services _____
   - D. Investment services _____
   - E. Insurance services _____
   - F. Business planning services _____

7. Would you like to see "personal finance" articles in *Colorado Medicine*? **Yes** ____ **No** ____
   A. If you answered YES, specifically what kind of articles would be of interest?
   1. _____
   2. _____
   3. _____
   4. _____

8. Do you have a written business plan? **Yes**____ **No**____
   A. Updated annually? **Yes**____ **No** ____
   B. Do you use an advisor? (attorney, consultant, etc.) **Yes**____ **No**____

9. Do you have a written personal financial plan? **Yes**____ **No**____
   A. Updated annually? **Yes**____ **No**____

10. How are your investments actively managed?_____
_____

11. Do you have a financial advisor? **Yes** ____ **No** ____

12. How often do you review all your insurance needs? _____

13. Do you have an insurance advisor? **Yes** ____ **No** ____

14. Do you do an after tax cost analysis of your liability management for your business?
Yes ____ **No**____

15. Personally? **Yes** ____ **No** ____

16. Beginning in January 1997, HWC Group/Merrill Lynch will offer priority financial services. Will you be interested? **Yes** ____ **No** ____

Optional
Name: _____ **Phone #:** _____

Thank you for your cooperation!

Computers in Medicine? Are you kidding?



by Claude S. Poliakoff, MD
CMS Committe on Medical Informatics

What possible benefit could an inanimate box provide for a clinician? After all, you are a finely trained physician, with a reputation for thorough inquiry into history of illness combined with an uncanny capacity of making physical observations on the condition of a human being. So how can a computer that knows only the difference between on and off, yes and no, help you do a better job? In a nutshell, you have the uncontested imaginative advantage, but the computer's memory beats ours hands down.

All physicians desire to be efficient and thorough in patient care. We want to obtain the best error-free results possible in the current era. Regardless of how entrepreneurial a physician may be, acknowledging that we are all human beings, there isn't one of us who would purposely provide inferior care in order to boost monetary gain. Why do we attend continuing medical education meetings? Even in states where CME credits are no longer required for licensure, physicians still seek out continuing medical education on a life long basis. The answer is obvious, better patient care and insatiable curiosity!

What has this all to do with the role of computers in medical care, you ask? I would only suggest that you consider the number of specialties and new subspecialties that exist in medicine today, unknown as realms of endeavor 30 years ago. Clearly, the reason for all of this domain segmentation is the virtual impossibility of any single one of us mastering all the data being uncovered across all specialties. Now, I realize that all of you have exceptional memories. Without it, you would have never succeeded in completing your medical education. However, not only do we as clinicians seek to provide the best possible care with virtually zero error tolerance, but our society is similarly conditioned. Why else does medical liability litigation thrive in this country?

I propose to you that the computer, with its flawless memory can help both our patients and ourselves. Granted, computers have entered the world of medicine through the accountant's office. Accountants may worry about losing charges for goods and services rendered by the organization for which they work. But clinical use of computers is infinitely more productive, both from medical quality and cost accounting standpoints. How many lost aspirin charges could be recuperated by eliminating unnecessary duplication of diagnostic studies, unnecessary tests and hazardous interventions?

Information systems throughout the world have elegantly demonstrated that once we achieve consensus as clinicians regarding specific clinical settings (no mean feat), we can streamline the clinical evaluation process or therapeutic intervention by programming sequences into a computer network. When a patient has a critical value in the laboratory or in the radiology department, within specific parameters, the result itself either in the laboratory or in the radiology department can automatically trigger an alert page to you, to accelerate

"So why should we embrace computers in medicine? Why should we change our ways?... Does evidence-based medicine justify such a change?"

(Continued from previous page)

any intervention you would wish to initiate. How many times have we all discovered important abnormalities casually on making rounds at the hospital? How many times have outpatients appeared with alarming values from the laboratory or the radiology department, that could well have been treated a lot sooner?

"Cookbook Medicine", where have I heard this before? What have we learned throughout our medical training? Have we not learned recipes, perhaps more intellectually described as diagnostic or treatment algorithms? What is the difference between algorithms and recipes? I would contend the only difference is one of complexity and sophistication.

So why should we embrace computers in medicine? Why should we change our ways? We see patients, ask questions, do physical exams, order assortments of diagnostic studies, followed hopefully by therapeutically successful medical or surgical interventions. It seems to be working pretty well, why change? Does evidence based medicine justify such a change?

We believe we have been practicing evidence based medicine throughout our careers. We read journals, attend seminars, examine experimental data, come to conclusions and apply them to our practices. I would suggest that we try to do this, but only partially succeed. How often are we certain in our deliberations, regarding a given clinical situation? When we are uncertain, how often do we drop everything to do a library search for an evidence based decision, whether in the hospital library, office or home? If I am lucky, I for one get to the medical library perhaps once a month. I don't see many of us there when I do get there, so I am inclined to believe that after practicing in this mode for 24 years, that many of you are subject to the same restrictions. I know that you will all agree that we are most sensitive to assimilating new information on a clinical problem when faced with an example thereof. All of our conferences are intellectually stimulating, but often do not lead to permanent behavior change. Very few of us can perform prospective double blind studies in our practices. A very small number of us can pursue retrospective studies, with all of the academic limitations that I need not review for you.

We have, in our own community, ongoing clinical experiences. If only we as a community were to adopt a common clinical vocabulary, we could:

1) appreciate the clinical variability of our population; and
2) generate some very revealing outcome studies, admitting the retrospective nature thereof, inviting us to proceed to randomized double blind studies.

We all remember being assigned chart reviews as residents and fellows, to generate clinical papers for our professors. If there is a physician amongst us who enjoyed doing these chart reviews, clearly such an individual would not derive much benefit from the computer in outcome studies. I, for one, never enjoyed such chart reviews. If we adopt a common vocabulary and agree to change our method of clinical documentation from the narrative free text tradition to a hybrid structured text (using menus of communally accepted terminology) plus the free text necessary for some of the subtleties of clinical evaluation, we can then, with computerized records, generate reports in minutes rather that months to help us improve our care.

"Improved care" should be defined. It is not only "better results", but constitutes fewer complications, perceived and treated earlier, for less money. Realizing that money is crass, I would only refer you to the success of modern automobile manufacturers, with their effective products. Compare the cost/mile of a Ferrari with that of a Saturn. Current medical care can cost as much as the former. Do most of us have problems denying ourselves Ferraris?

Our computers can be configured to offer us diagnostic as well as therapeutic alternatives, provided we the clinicians are *directly involved* in information system implementation. We can display alternatives on computer screens that may even be more appropriate for a given patient by virtue of drug interactions, disease/drug adverse reactions, even if the cost of the optimal medication is higher that the one we would have chosen.

I dare say any one of us, having undergone a healthcare encounter personally, would appreciate being spared some of complications all of us have seen and treated. Though computers are certainly not as imaginative as clinicians, their memories are flawless. Virtually every realm of endeavor in our society has been affected. I would invite you all to investigate these potentials for your own practices. I know your office staff would certainly appreciate expediting their repetitive tasks. But, I would invite you to investigate the *clinical* benefits that can generously benefit all of us.

Don't let them Suffer In Silence!

For resource materials and patient information, contact:
Ellen Stein at the CMS offices at 779-5455 or 1-800-654-5653 or E-mail *Ellen_Stein@cms.org*.
There are so many things you, the physician, can do to help people in distress and whose lives are actually endangered. We have posters, physician guidelines and resource cards available for use in your office. Carry the calendar (included in this issue) to remind you and your associates of what needs to be done to save lives.

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Orders must be received by February 28, 1997 for this quarter's printing.

Order today and let your patients know that you are a proud member of the Colorado Medical Society advocating excellence in the profession of medicine.

by Marilyn Rissmiller,
CMS Division of Health Care Financing

Avoid claims processing delays

"The top reasons for delays in claims processing..."

According to the Medicare Part B Carrier, Blue Cross and Blue Shield of North Dakota, the problems listed below are the top reasons for delays in claims processing.

1. **Invalid beneficiary HIC number –** Validate the patient's number by making a photocopy of the card.

2. **Invalid diagnosis code –** The 1997 ICD-9-CM Diagnosis Code book must be used to report the complete diagnosis code (3rd, 4th or 5th digits as indicated).

3. **Missing or invalid UPIN –** The name and UPIN number are required for the referring physician (e.g., for consultations), and for the ordering physician (e.g., for certain diagnostic services).

4. **Missing documentation or report–** When reporting a miscellaneous procedure code or using modifier -22 to identify unusual circumstances, a report must be submitted with the claim.

5. **Dates of service do not match the number of services –** If the dates of service are reported as an inclusive date range (e.g., 1/1/97 to 1/5/97), the number of services must match (e.g., 5).

6. **Invalid procedure code –** The most current CPT and HCPCS procedure codes and modifiers should be reported. (There is a grace period of approximately three months for most 1997 CPT codes.)

Addressing these problem areas will result in faster claims processing, fewer unnecessary denials, and fewer development letters.

CORRECT CODING REVISITED

Medicare's Correct Coding edits have been in place for about a year. In a recent study, HCFA identified the top ten coding combinations that, according to these edits, are being billed incorrectly. The "comprehensive" codes are listed in Column 1. The codes listed in Column 2 are considered "bundled" into the comprehensive codes. (If billing the Column 1 code, do not bill the Column 2 code in addition.)

	Column 1	Column 2
1)	93010	93042
2)	71020	71010
3)	94060	94375
4)	93000	93040
5)	94010	94375
6)	93880	93325
7)	94060	94200
8)	85025	85595
9)	93015	93000
10)	93018	93010

If you have coding questions, you can contact Marilyn Rissmiller in the Health Care Financing Department at 779-5455 or 1-800-654-5653, extension 2428.

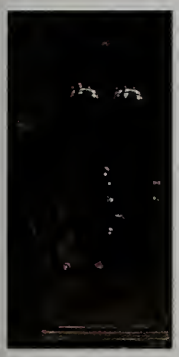
Special Section

The Associated Press story below is only a year old and the writer, (Jeannine Aversa) quoted executives of the companies as saying the new technology wouldn't reach the consumer for another five years. One year later and much of what was projected then is available on the open market today. For the physician or other busy professional, cellular phone, paging, text transmission, caller ID, intra-office wireless paging, video conferencing, telecommuting and transmitting of medical information, imaging and X-rays to doctors and institutions are now available through more than one of the major carrier services or peripheral providers of paging and cellular phones.

We may have to wait a while to see what "smart home" wireless systems will offer, but change and revolution is just around the corner or, as you might say, "waiting on the other line".

To help CMS members better underestand the technical communication revolution, ***Colorado Medicine*** has put together this special section, featuring information provided by the major suppliers of these services, or information about these suppliers we have garnered from their marketing publications or press releases. None of the informaiton included herein implies an endorsement or sponsorship by Colorado Medical Society of the product or service described.

Editor







New airwave technology greets 21st century

Wireless systems to expand on 'virgin' frequencies

WASHINGTON-AP (January 30, 1996) --Car radar to warn of approaching trouble. Wireless gadgets to control our appliances and security from an easy chair.

Federal regulators are unlocking a vast, virtually unused portion of the public air waves to make these and not-yet-imagined other commercial services available -- and to open a window on the 21st century.

It began in a little-noticed action last month as the Federal Communications Commission began delving in the segment of the public airwaves known in telecommunications lingo as millimeter waves.

Technically, the frequencies are located above 40 gigahertz - far past frequencies used for television, radio and cellular phones.

"That's where the virgin territory is," explained Mike Marcus, the FCC's associate chief of technology.

Because of their location on the spectrum band, the frequencies have extremely limited use compared with other frequencies. The waves can travel only short distances - about half a mile on a clear day - but can carry lots of information, including voice, video and data.

Largely because of their limitations, companies have had little interest in using the frequencies for many years. Advances in technology have changed that. General Motors, Hewlett-Packard, AT&T and Apple are among companies exploring ways to apply the frequencies to new services and devices. "I think this is very definitely something that is going to be important to the marketplace and to people in their daily life," AT&T government affairs director Frank Mathewson said.

According to information supplied by the companies to the FCC and described in interviews, possible uses include:

- Radar systems for cars to alert drivers to potential collisions. General Motors, Ford Motor Co., Chrysler Corp. and VORAD Safety Systems Inc. have filed comments with the FCC expressing interest in using millimeter wave technology in such a way.
- Wireless systems to make homes "smart" by controlling appliances, heating and cooling, and security systems.
- High-capacity wireless links to connect computers within offices or communications systems from building to nearby building.
- Wireless links to connect phones, pagers and other communications devices throughout a college campus or airport.
- Video conferencing, telecommuting and transmitting to doctors and institutions detailed medical information, including images and X-rays.

Some of the ideas are not necessarily novel but are noteworthy because they harness frequencies without commercial uses before now. Company executives also believe they will be able to offer high-speed data transmissions and other similar services more cheaply than companies using different technology.

"The exciting thing is not what companies are thinking about now but what it might make available in the future," said Cynthia Johnson, government affairs director for Hewlett-Packard.

Executives of these companies say making the new technology available will take at least five more years.

The only current uses for millimeter waves are by radio astronomers, who use a few mostly for weather observation, and by the military.

Questions about telemedicine not yet answered

by Chet P. Seward,
CMS Communications

"Lite Licensing" for interstate practice by telemedicine? How about a "Board of Telemedical Examiners?"

It's no wonder that states are struggling to devise a policy regarding the regulation of telemedicine. Licensure issues alone have created a host of difficult questions. Should out-of-state physicians practicing telemedicine on patients in a state be required to have full licensure in that state? Or should they be allowed to obtain a special purpose license used strictly for the practice of telemedicine?

Silence is consent?

Medical Practice Acts (MPA), which empower state Board of Medical Examiners (BME), are basically silent with regard to telemedicine. The practice was not imagined when most MPAs were written. Telemedicine has not become a priority issue for many BMEs because they lack the time, technical expertise and manpower to tackle the regulations that are necessary for the licensure of telemedicine. Most MPAs do not have specific stipulations regarding the practice, and as a result many state boards are legitimately reluctant to institute new, standard-setting regulations. In the absence of those provisions most BMEs require full licensure.

Telemedicine is a hot legislative issue at the national and state capitols. For the past two years telemedicine bills have been heard and killed at the Colorado Legislature. This year House Bill (HB) 1050 has reignited the debate, but its chances for survival appear to be much better than previous years.

It is safe to say that no BME, Colorado included, is excited about legislative changes which will add to their already heavy load. In an attempt to head off legislation like HB 1050, the Federation of State Medical Boards (FSMB) drafted a model act to regulate telemedicine in 1995. This mock bill seeks to provide special purpose licenses for telemedicine. Also known as "licensing lite," the model bill has received little fan fare from state boards who are protective of their state autonomy. The AMA is opposed to these special purpose licenses because of concerns about quality care.

Square peg in a round hole?

A couple of states have actually enacted legislation regulating the licensure of telemedicine. A Kansas law, which will undoubtedly affect some Colorado physicians, took a conservative tack by requiring full licensure of out-of-state doctors. Texas has taken a more innovative approach by upping the ante for doctors who want special purpose licenses. These expedited licenses require that physicians be board certified and have no current or past medical board disciplinary action. If a doctor doesn't meet those standards, then he/she would have to obtain full licensure.

Colorado's HB 1050, which is currently awaiting a hearing in the Senate HEWI Committee, would require full licensure similar to the Kansas law. Specific exemptions would allow for emergency and incidental consultations. The difference with HB 1050 (as written at press time) is that out-of-state radiologists and pathologists could practice telemedicine on patients in Colorado as long as those patients were under the care of a referring physician in this state. CMS believes that this may open the door for managed care companies to farm out telemedicine procedures to out-of-state physicians who offer the cheapest prices. Colorado doctors would thereby face unfair competitive disadvantages. CMS is working with other specialty societies to amend this bill.

The big question remains – how should licensure for telemedicine be regulated. Given the facts that the FSMB proposal has met with little or no promotion among state boards, state and federal legislation has and will continue to define and regulate the practice in varying degrees, and many state BMEs have "silently consented" to full licensure requirements, telemedicine has the potential to spark an even larger debate about national licensing standards.

So what's the answer? Perhaps it is too early to say. Undeniably telemedicine has become a public policy issue which will require increased attention from all interested parties including physicians, state boards, managed care and legislators. The questions have really just begun, but the promise of the application will undoubtedly assist in creating the answers.

Telemedicine rides the Internet



Flashback! *The following sidebar appeared in* ***The Internist, February, 1996.*** *It was a good description then for the beginner, and it is still good today, although one year later the terms and conditions have changed dramatically. We do, however, still have many beginners who haven't even stuck a toe in the pond. Don't be afraid of it. Gert right in; it's the only way you can stay in touch with today's (and tomorrow's) medical practice.*

C/M Editor

Surfing the Internet: Physicians Catch the Wave to Information

Once viewed as a nonessential luxury for university students and researchers, the computer network known as The Internet has worked its tentacles deep into main-stream America. Whether the vehicle is standard office hardware, a personal home computer or a portable laptop, users are going on-line to access information databases across the globe. Physicians also are turning to cyber-space--the realm of computer-accessible resources--for information as well as communication with colleagues and patients.

Because computers are capable of transmitting information at high speeds, members of the medical profession are discovering a wealth of knowledge at the click of a mouse. Using an online service, such as *CompuServe, America Online* or *Prodigy*, users may access the "information superhighway" by maneuvering a mouse through icon-driven menus to scan various databases, including medical research bulletin boards, university libraries, medical job centers, or health-related "chat" rooms such as Physicians' Online.

Since most online services charge hourly premiums over and beyond monthly membership fees, hopping from one access point to another can become costly. Becoming familiar with a few simple terms can maximize your time as you start out on the Net:

Browsers: These software tools can be used to maneuver through Internet resources and the World Wide Web.

E-mail: These electronic mail messages can be sen from one location to another via computer. E-mails can be sent to one person or a large number of individuals on mailing lists. In some areas of the country, physicians have taken to E-mail, connecting with patients and colleagues while avoiding the hassles of telephones. However, sending E-mails to patients may carry legal ramifications. Before offering tips and advice, be aware of liabilities.

Gopher: This is a widely successful type of menu search. Internists can use gophers to connect to the National Library of Medicine or other medicine-related sites, such as *Medsearch America,* a medical-profession job service. There are thousands of gopher sites on The Intemet.

Home page: These are sites on the World Wide Web, usually represented by graphics. Typically. home pages give a brief description of the organization occupying that site.

Hypertext: Utilizing hypertext, users can "link" from site to site. The text links usually are indicated by underlines.

Internet: This term refers to the worldwide research network. Be careful not to confuse The Internet with *internet,* the term used to describe a connection between two or more smaller networks.

Listserv: The most common form of mailing lists. List-servs are online discussion groups made available to users who subscribe to the list.

Modem: These devices are connected to a computer and to a phone line, enabling computers to "talk"--or exchange information--via telephone lines.

Network: A network is a connection between two or more computers, enabling users to share resources. A connection between two or more networks constitutes an internet.

Newsgroups: These groups comprise the *Usenet* network, a global scheme of discussion groups. There are more than 10,000 Newsgroups on *Usenet.*

URL: A uniform resource locator is the standard format for addresses of any resource on the World Wide Web (WWW). For example, the home page of Physicians' Online has the following URL: ***http://www.po.com.***

World Wide Web: Commonly abbreviated WWW, this phrase loosely describes the global web of resources that can be accessed using various software tools and browsers, and its capacity to combine text, graphics, sound and videos.

--Tammy White





It's difficult to report on a revolution because developments occur rapidly. Typically, who are the major players in the satellite, cellular, wired and wireless communications fields today? We have gathered together those in our area which we know about. There may be others. The names change often and mergers and acquisitions are occurring. Technical developments are flowing in almost liquid form and, like water, it is difficult to catch and describe separate molecules. We won't try... but we urge you to look at the information we have reproduced on the following pages.

DCC Solutions*

When you feel ill you go to your family physician. These good doctors practice general medicine. When warranted they will refer you to a specialist.

When you need a communication specialist, you go to a company that can diagnose your problem and prescribe a solution. *DCC Solutions, Inc.* is just that - a company that has certified master technicians on premises. In-house customer care representatives means your call is answered, by a real person, within 15 seconds. We are the only *AirTouch* Co-carrier west of the Mississippi.

DCC Solutions, Inc. finds and provides for our clients the best in products, services and price. This includes cell phones, pagers, *Nextel* products, E-Paging, mobile fax, and wireless modems for laptop computers.

Walk into *DCC Solutions'* 3,000 sq. ft. showroom/office and you can choose from a selection of the best phones manufactured: *Motorola, AT&T, NEC, Nokia, Oki, Audiovox.* We have picked the best from each maker for you.

More that a dozen of our 25 sales representatives have been through Nextel's training. We carry their ***PowerFone™***, a unique combination of two-way radio, cellular phone and alphanumeric pager. Also available is the ***Raven***, the military spec version of the ***PowerFone***. We carry all of the accessories for both versions.

Another unique *DCC Solutions* service: E-paging. An extremely new concept, this offers the ability to know within minutes of receipt of an E-mail, who sent it, its contents and what reply, if any, is necessary. You will receive an alpha page within two minutes of the E-mail arrival.

There have been some startling advances in wireless computer technology. One is the wireless modem that allows you access to the internet from you laptop computer, wherever you may be in the world. *DCC Solutions* provides PCMCIA cards, attaching cords and the other accessories necessary for the busy physician to stay in touch from anywhere.

DCC Solutions does not have the huge infrastructure that the major airtime carriers must support. This allows us the luxury of providing the best airtime rates for phones available in the state.

At a time when most companies are reducing the size and effectiveness of their customer care and service divisions, *DCC Solutions'* is growing rapidly. This is due in part to our in-house certified technicians. A new store just opened in Colorado Springs. Another is opening in the Greeley area by April and another opening in downtown Denver in March.



Mr. Marcus Allen, President of DCC Solutions, Inc., displaying the number of product and service lines handled by his company. He's holding the "Star Tach" which, when not in use, folds to nearly the size of a typical pager. Nearby is his lap-top computer which, with the addition of the PCMCIA card, can be connected to your cellular phone for use with a data modem, facsimile send and receive and downloading from the Internet.

***DCC Solutions, Inc.*, a locally owned Colorado corporation, is currently located in Denver at 2553 S. Colorado Blvd. Phone: (303)753-4600 FAX (303) 753-4646. In Colorado Springs DCC Solutions is located across from the Citadel Mall at 771 N. Academy Blvd. Phone: (719) 572-2440, FAX (719) 572-2441.**

digital messaging, Narrowband Advanced Mobile Phone Service,



Airtouch Cellular

At Airtouch Cellular, we're continually working to upgrade our systems and our service to provide cellular customers with added convenience and value. In 1993, we began making upgrades to our network that enable us to offer the digital features many of our customers are using today. Ultimately. state-of-the-art digital tecbnology will be readily available to all AirTouch Cellular customers.

Today Digital Messaging Services, made possibe by Motorola network technology, give AirTouch Cellular customers the benefit of having cellular, paging and voice mail services all rolled into one pocket-sized ***"MegaPhone."***

In the near future, cellular customers in AirTouch's major markets can expect to have access to digital services made possible by CDMA (Code Division Multiple Access) technology. This time-saving tecbnology -- marketed by AirTouch under the name of Powerband[SM]-- is widely recognized as the ultimate digital technobgy for cellular customers.

With AirTouch's 13 kilobit CDMA network, customers will enjoy extraordinary call quality, reliable connections, iron-clad security and five full hours of talk time on a single battery. The feature-rich service gives users tbe power of a pager, answering machine, Caller ID box and cellular phone in one eight-ounce handset.

Powerband CDMA phones will operate in both the digital and analog mode, giving customers the ability to use their digital cellular phones on analog, as well as digital systems, throughout the country. With millions of customers on the existing cellular network, high quality analog service will continue to be the workhorse of the wireless industry. With Powerband, customers will be able to enjoy the best of both worlds.

Today's Digital Features

Until Powerband is widely available, cellular customers can experience the convenience of the following digital features, along with a voice mail box in the Digtal Messaging Services package:

- Short Messaging: This service allows customers to receive a text message, such as "Call Home," on the number display screen of their cellular phone. Callers can send one of seven predetermined messages by using the keypad on their touch-tone phone.
- Message Waiting Notification: This feature alerts a customer -- with a short beep -- that a voice mail message has been received. With a push of a button, the user is automatically connected to voice mail and can receieve the message.
- Call-Back Number: When a cellular customer's phone is busy, turned off or out of the service area, callers can use this feature to send a call-back number. The phone stores the caller's number. allowing the cellular customer to return the call by simply pressing the SEND key.

All of these features are made possible by a digital control channel between the cell site antanna and the cellulat phone. Digital signaling and control is a key feature of Motorola's Narrowband Advanced Mobile Phone Service (NAMPS) technology.

NAMPS not only provides digital features, it improves the quality and privacy, and boosts system capacity up to 300 percent. As AirTouch Cellular prepares for the commercial implementation of CDMA digital technology, NAMPS offers an elegant interim solution to meet growng capacity demands and to familiarize customers with new digital services.

AT&T

Colorado cell phone users can now find out who's trying to call them and read and send text messages via newly launched AT&T digital technology.

The Digital PCS technology, now available in AT&T Wireless Service's Colorado area, marks the phone giant's latest move in an increasingly competitive wireless communication arena in the state.

The technology uses AT&T's cellular network with upgraded digital control channels that allow the features to reach individual phones, said spokeswoman Mary Ireland.

Using the expanded features requires purchase of a new digital phone with prices starting at $179. Monthly service charges start at $24.99 for up to 30 minutes. Costs go up for additional features.

"People can mix and match and use features that work best for them," Ireland said.

Available new features include:

- Longer battery life -- up to 40 hours.
- Attempts made to deliver messages for 72 hours. Short text messages can also be sent to the phones.
- Caller ID, allowing subscribers to see who's calling.

AT&T Wireless Services was born from the purchase of McCaw Cellular Communications Inc. in 1993. The national launch of the digital service was in October.

AT&T is one of two cellular phone providers in the metro area, but three

(Continued)



Code Division Multiple Access, mobile fax, wireless modems for laptop com-

AT&T

others using somewhat different technology are planning to launch service early this year.

Ireland said an advantage of the AT&T service is that the phones, made by two manufacturers, can be used even in areas where the new advanced digital technology is not available. AT&T's cellular network includes 5,100 cities in North America.

Nextel

Go Beyond Cellular

*by Chris Nikont**

In an effort to keep up with the demands of their job, medical professionals have turned to the wireless communications industry. It is rare to find a physician who does not own a cellular phone and even rarer to find one who does not own a pager. But there are problems with pagers, conventional cellular phones and even PCS.

Nextel's new alternative, the ***PowerFone***™ not only eliminates the inherent risks of traditional wireless and PCS devices but also delivers the means to more efficiently communicate and save as much as 30% on traditional wireless bills immediately! Nextel's digital technology offers the following unique solutions:

- Cellular Pooling - Only Nextel has this remarkable new money saving program. It allows everyone in each physician's office to use airtime from a single pool. No more unused minutes, less costs.
- Digital Cellular - Nextel's cellular system has always been digital. Digital systems are completely private, cannot be scanned, and cross-talk does not exist.
- Instant Conferencing - Another exclusive Nextel service that allows you to contact your office or another physician with the push of a button-no dialing, no ringing-and you can talk to 1 or 100 individuals at the same time.
- Paging - The system allows both alpha and numeric pages. Even if the ***PowerFone***™ has been off, the page is still recorded and delivered to you when you turn it on.

A physician's life has always been busy. Patients, hospitals, office staff, meetings, and consultations dictate their lives. Nextel's unique solutions help alleviate communication problems at significantly higher savings.

To learn more about keeping on top of your schedule and always being in touch, call 1.800.Nextel 9 or your local Nextel office.

**Chris Nikont is a Senior Account Executive for Nextel Communications at 303/598-6003.*

Service**Alert**™ PAGING

by Debra S. Witham
*Western Marketing**
(303) 798-2623

A silent paging system provides a quiet means of communication so that patients and staff are not disrupted unnecessarily. Service**Alert**™ offers a number of affordable, reliable, customer owned paging systems designed to increase office efficiency and provide instant and discreet communication between staff members.

Service**Alert**, founded in 1989 in Boulder, Colorado develops, manufactures and markets wireless communication products for a number of industries including health care, retail, hospitality and manufacturing. In 1993 Service**Alert** was chosen by Motorola to manufacture the 1400M series of wireless paging call panels. Service**Alert** products support Motorola pagers and are capable of sending digital as well as text messages up to two miles away.

By owning your own system, there are no monthly usage fees. You can send as many pages as you want without any additional cost. Customer-owned paging allows you to simply touch pen to pad and instantly send a message to a pager instead of having to call a paging service and wait sometimes three minutes for the page to go through. You can also personalize the system to meet the specific needs of your practice.

The newest Service**Alert** product, the 6100M Message Maker, allows text messages to be sent to an alphanumeric pager. The Message Maker gives you 52 user programmable buttons for building frequently used text messages. The 2500M Desktop Unit lets you send up to an eight digit message to as many as 255 pagers. Service**Alert**'s Wireless Push Button Paging system gives you the ability to instantly and silently page an associate from exam rooms. A small wireless button is placed in each room and the single press of that button instantly pages a Motorola vibrating pager.

**Western Marketing is a locally owned Colorado distributor for ServiceAlert products.*



Casio's Videophone

Casio Phonemate's plug-and-play LT-70P Videophone is the only communications tool enabling "show and tell" transmission of full-screen, high-resolution color images with simultaneous audio over a single, regular phone line using a standard television.

Portable, easy to use, the LT-70P features a unique sequential video format that displays a standard full-frame image every 3.5 seconds, or high-resolution image every 30 seconds.

The LT-70P is appropriate for a variety of telemedicine applications, including bringing medical services to those who have difficulty traveling to medical facilities, such as nursing home residents; providing health care opportunities to rural locations, where the availability of specialists may be limited; and allowing physicians to quickly consult with each other across town or around the world sharing both video and audio information.

Teaching institutions have found the LT-70P to be a valuable training aide. The UCLA School of Nursing, for example, uses the product to save time and increase efficiency as part of its ongoing clinical practice assessment of nurse practitioners.

UCLA nursing school students take LT-70P Videophones to patient assessments in hospitals and clinics throughout Southern California, and then transmit live video images with simultaneous audio to faculty members on campus -- saving a significant amount of travel time for staff evaluators. With approximately 20 faculty members to 300 graduate students, the travel time saved allows for more clinical site visits and evaluations per student. The produdt is also used by the university for videoconferences with clinical instructors.

The Videophone is also ideal for home health care and diagnostic purposes.

"The health care industry has been waiting for videophone technology," said Tom Greggs, president of BioCommunications, a Wilton, Connecticut-based videophone marketer. "Once medical professionals know it exists and how it works, it will become an important and commonly used communication tool.

Even paramedics can benefit from the ability to quickly and easily transmit video images from one site to another."

"The LT-70P is ideal for telemedicine because it lets patients in remote areas communicate with physicians, showing them how an injury is healing, for example," said Bennet Bayer, National Sales Manager for the Advanced Communications Products Division at Casio Phonemate.

The LT-70P can transmit images captured with a camcorder, photo CD, document stand or digital camera, such as Casio Computer's QV-10. Images can be stored in the internal memory or on a VCR, and can be printed on an optional video printer. For those who want to keep an eye on medical facilities, offices, laboratories or other locations for security purposes, the LT-70P also otfers a new Telesurveillance application which allows users to engage a sister unit to monitor a remote site.

With the touch of a button on the remote control, the LT-70P can switch between built-in or optional cameras.



Casio's Phonemate LT-70P Videophone transmits a full-screen, high-resolution color images with simultaneous audio over a single, regular phone line .

The LT-70P supports connection to an existing closed-circuit television (CCTV), a wireless camera or external cameras. The next generation product, a customizable version of the LT-70P called the LT-70PC, can interface with up to eight CCTV cameras for telemedicine/telesurveillance, including pan, tilt and zoom cameras using RS-232 connections. The unit can operate up to eight control switches for machinery or simply turning on a light, and as many as eight alarm system contacts can trigger image storage and dialing of one or more phone numbers for data transmission. LT-70P units at watching stations can access the LT-70PC.

The LT-70PC can be connected to medical image databases and used for sequential video mail when it is not convenient to schedule a point-to-point live connection.

CASIO PHONEMATE has established a nationwide network of vertical market specialists for the LT-70P Videophone and LT-70P Tele-surveillance Application. The suggested list price for the LT-70P is $1,899, and the LT-70PC $2,200, including a computer integration package.

*Casio Phonemate designs, engineers and markets telecommunications products for business, home office and home use.

Telemedicine: bigger, better, Now!

by Chet P. Seward,
CMS Communications

The practice utilizes 'new tools, not new medicine'.

Innovation. For centuries it has been the foundation upon which the medical practice has been built. If there is anything that is certain about medicine, it is undeniably true that physicians are constantly striving to improve medical care through innovation. It can come in the form of the most advanced technological and clinical breakthroughs, to simple changes in diagnostic techniques. The truth is that physicians will always be hungry for more innovation because it is the key to providing the best possible patient care.

For some strange reason that appetite has been abated when it comes to telemedicine. Amazingly, this new, and continuously developing medium of medicine has not been tapped as a resource for most physicians. Oddly enough, many doctors strictly perceive telemedicine as an interactive means to consult patients via video. At best this is a disjointed view of an application that can potentially benefit patients around the globe. In truth, telemedicine can do much more, including physician to physician communication, professional and patient education, image transmission, patient monitoring and results reporting. As telemedicine evolves these and many more applications will become the norm.

Reimbursement issues continue to plague telemedicine because definitive studies on whether it is cost-effective and safe have yet to be fully supported. Government agencies have balked or stalled on the issue, and as a result doctors continue to be leery. Licensure and competition questions have fueled more internecine wars between different providers. Finally, gaining proper access to stable networks, privacy issues and the cost of service also threaten to dull the menu of telemedicine's growing usefulness.

Despite the bitter taste of all of those factors, acceptance of the usefulness and cost-effectiveness of telemedicine is growing. Moreover, the continuing growth of the Internet has reinforced the conclusion that telemedicine can and must play a bigger role in medicine.

The technology needed for telemedicine has been around for years. There is nothing gourmet or exotic about it; as the title of a recent *AM News* article concludes, the practice utilizes "new tools, not new medicine". The November 11, 1996 article makes a number of important points that are noteworthy including: statistics show that physician-patient video consultations have increased by 300% nationally; a new ground-breaking report by the Institute of Medicine may finally provide a framework to thoroughly evaluate telemedicine programs; and the US Dept. of Health and Human Services (HHS) recently launched a program in which Medicare would pay for telemedicine consults. The article also notes that as the business of health care grows, large managed care companies will create networks and find new clients, thereby addressing access and competition issues. On a daily basis, international telemedicine projects are proving its cost-effectiveness.

The *AM News* article also highlights the beneficial boom of the Internet and its impact on the future of telemedicine. Not only does the logic behind the Internet bolster the case for telemedicine, it also has helped to technologically advance delivery systems while simultaneously lowering telecommunications costs. The number of high profile projects fed by the HHS reaffirm telemedicine's growing importance. Now the only thing left is for more doctors to embrace the practice.

In the end, the figurative macaroni and cheese housecall is not on the palate of today's average doctor. Much work is left to be done, however it is important to remember that telemedicine is not a gourmet dish requiring deep pockets and sophisticated tastes. Quite to the contrary, it is fast becoming a meat and potatoes entree in the practice of medicine by facilitating and providing quality care. The sooner physicians open their minds and appetites to its potential, the sooner they will find that telemedicine is a bigger, better way to help quench their hunger for innovation.

As integrated as you want to be...



When it comes to modern telecommunications, the new and the old seem to be blurring together. New digital products, like sleek cellular phones and mobile fax machines, and the tried and true telephone now have a common thread in their continuing rapid development. Personal communication service (PCS) is a relatively new way to connect analog instruments (e.g. traditional telephones using land wires) with digital equipment (e.g. cell phones which utilize digital radio waves bounced off satellites). Recently created when the Federal Communications Center (FCC) opened up an unused radio frequency to the public, PCS could further revolutionize the already hot telecommunications market by providing a new service by which *both* analog and digital signals can be sent.

At first glance PCS may appear rather uninspired. However, when you think about being able to access your telephone, your cellular phone, your pager(s), your e-mail and your voice mail(s) through one service, then the beauty of PCS is easily apparent. That is exactly what US West believes. The Denver-based Baby Bell recently won licenses to provide this new service to 53 markets in its 14-state region. The deal cost US West $57 million. Of that total the licensing for the Denver market amounted to $5.3 million. The mile high city will showcase this new service which should be ready by the middle of this year. Expansion to cover the whole front range will occur soon afterward.

"PCS goes above and beyond current communications technology," said US West Public Affairs spokesperson Janine Wilson. The biggest plus for this untouched region of the radio waves is that it allows people more choice. The service could be ideal for today's busy medical practice environment because it will provide physicians with the opportunity to be as integrated as they want to be. Car phones, pagers, office phones and computers can now all be married together into one service. Moreover, because PCS utilizes higher frequencies than the traditional cellular phone, the service offers better quality, fewer dropped calls, less static, lighter phones and longer battery life. The drawback will be that the PCS area will be limited initially to a few miles as the service is expanded to cover the Denver-metro area and then the front range. AT&T, Sprint and Western Wireless also plan to offer PCS in the coming year.

Years ago analog equipment needed telephone lines, and telephone poles sprouted so quickly they became the figurative official tree of many neighboring states. Then the push for digital technology spawned the need for satellites and satellite dishes. Now PCS has stepped up the evolution of telecommunications even further by integrating the two. For years to come cellular may be the choice for many people. "Wireless is where the industry is going," said Wilson. However, PCS may well be the next generation of telecommunication.

"PCS could further revolutionize the already hot telecommunications market... by which both analog and digital signals can be sent."

"You can't tell the players without a scorecard."

and **THE** scorecard is
the twice-monthly newsletter

COLORADO MANAGED CARE©

COLORADO MANAGED CARE© is the state's first complete summary of acquisitions, mergers, buyouts, closures and the myriad of other changes in the healthcare field.

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Please take note of the address change for The Colorado Physician Health Program. *Our new offices are now accessible to physicians with mobility impairments.*

CPHP serves the needs of the Colorado medical community through problem identification, treatment referral, monitoring, clinical consultation and support to individuals and their families.

Physicians who may be experiencing physical, emotional, or psychological problems may elect to refer themselves for evaluation. Family members, colleagues, or other concerned individuals may also provide a referral for a physician in need of assistance.

The Colorado Physician Health program is a non-profit organization established by the Denver and Colorado Medical Societies. These physicians recognized that organized medicine had an important role in physician health: identifying and rehabilitating physically or emotionally distressed and impaired physicians.

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1997 CMS Interim Meeting

March 7-8, 1997

Holiday Inn Denver Southeast

Features

Kathleen Weaver, MD, will keynote the 1997 CMS Interim Meeting of the House of Delegates. As a follow up to the 1996 Annual Meeting, Dr. Weaver will discuss how electronic medical records (EMR) can assist physicians in the practice of medicine. A member of the Medical Advisory Committee for MedicoLogic electronic medical records, she has been a strong advocate of the EMR since her office went "paperless" in 1993. Dr. Weaver will elaborate on the numerous possibilities of computerized medicine by addressing some of the apprehension that many physicians have about the EMR. She will explore how the EMR can actually help you to restore your satisfaction in the practice of medicine.

Dr. Weaver lives in Portland, Oregon where she has been a practicing internist for the past 26 years. In addition to her full time practice, she has been very visible in local, state and national levels for organized medicine especially in the American Society of Internal Medicine where she was on the Board of Trustees for ten years and served as President in 1994. Dr. Weaver is an Alternate Delegate to the AMA from Oregon for the past four years, and is one of 10 women physicians on the AMA Advisory Panel on Women in Medicine. In 1994 she was appointed by Governor Roberts to the Oregon Health Services Commission for a four-year term. She holds clinical faculty appointments at the Oregon Health Science University and Linfield College.

Ed Kelsay will speak at the luncheon on March 8, 1997 during the Interim Meeting. He is an attorney, medical association executive and president of his own medical practice management seminar and consulting firm. He also serves as the Malpractice Loss Prevention Manager for Oklahoma's physician-owned professional liability insurance company and as a risk manager consultant to several other physician-owned malpractice insurance companies around the United States.

Over the past 25 years he has given hundreds of talks to all kinds of audiences and conducted well over 1000 business management and/or malpractice loss prevention seminars for physicians and medical office personnel. A humorist and motivational speaker, Mr. Kelsay will provide a provocative look at the profession of medicine which you will not want to miss.

Ed served the Oklahoma State Medical Association in various capacities for over 28 years. Most recently he spent 16 years as the Association's General Counsel and Associate Executive Director, until leaving in late 1995 to become a full-time professional speaker and consultant.

In 1986 Ed Kelsay was one of the first 17 association executives in the United States to be awarded the ASAE Fellow designation by the American Society of Association Executives. He earned the Certified Association Executive (CAE) designation in 1979.

He is an adjunct instructor on medical and practice management for the Department of Family Practice a the University of Oklahoma Medical School and has written 17 booklets on medical office management and medical malpractice loss prevention.

Colorado Medical Society
1997 Interim Meeting

Holiday Inn Southeast
(Parker Road @ I-225)

Schedule

Friday, March 7, 1997

8:00 a.m.-5:00 p.m.	*Caring for Colorado's Underserved* Conference
1:00 p.m.-2:00 p.m.	Finance Committee
2:00 p.m.-5:00 p.m.	Board of Directors
5:00 p.m.-6:00 p.m.	Registration
5:15 p.m.-5:45 p.m.	Cocktails
5:45 p.m.-7:45 p.m.	*Caring for Colorado's Underserved* Dinner

Saturday, March 8, 1997

6:30 a.m.- 4:00 p.m.	Registration
7:00 a.m.-10:00 p.m.	Office open
7:00 a.m - 8:00 a.m.	Reference Committee Members
7:00 a.m.- 8:15 a.m.	AMA Delegation Open Forum
7:15 a.m.- 8:15 a.m.	COMPAC Board
8:00 a.m.- 8:30 a.m.	Credentials Committee
8:30 a.m.- 9:00 a.m.	House of Delegates - Opening Session
9:00 a.m.-12:00 Noon	General Membership Meeting
12:15 p.m.- 1:45 p.m.	Luncheon
2:00 p.m.- 4:00 p.m.	Reference Committee on Board of Directors/Constitution & Bylaws/Credentials
3:00 p.m.- 5:00 p.m.	Reference Committee on Health Affairs

Sunday, March 9, 1997

6:30 a.m -10:30 a.m.	Registration
7:00 a.m.-12:00 noon	Office open
7:00 a.m.- 8:30 a.m.	Arapahoe caucus
7:00 a.m.- 8:30 a.m.	Aurora-Adams caucus
7:00 a.m.- 8:30 a.m.	Boulder caucus
7:00 a.m.- 8:30 a.m.	Clear Creek Valley caucus
7:00 a.m.- 8:30 a.m.	Denver caucus
7:00 a.m.- 8:30 a.m.	El Paso caucus
7:00 a.m.- 8:30 a.m.	Larimer/Weld caucus
7:00 a.m.- 8:30 a.m.	Pueblo/Western Slope caucus
8:15 a.m.- 8:30 a.m.	Credentials Committee
8:30 a.m.- 12:00 noon	House of Delegates - Closing Session

Meeting Registration and Hotel Reservation Forms are on the next page.

This portion goes to CMS

Interim Meeting Registration

1997 Interim Meeting of the Colorado Medical Society, March 8-9, 1997, Holiday Inn Southeast

Name (***Please type or print***) _____

Name of Spouse/Guest (if attending) _____

Component Society _____ Office Phone _____

Reservations for Events and Meetings

(***Reservation deadline is February 21, 1997***. Reservations accepted on a first-come, first-served basis)

	Number Attending	*Cost*
Friday, March 7, 1997		
8:00 a.m.-5:00 p.m. Caring for Colorado's Underserved Conference	_____	Free
5:45 p.m.-7:30 p.m. Caring for Colorado's Underserved Dinner	_____	Free
Saturday, March 8, 1997		
12 :15 pm –1:45 pm Luncheon	_____	Free

Hotel Reservations

Please use the hotel reservation form below to make your reservations directly with the Holiday Inn Southeast. **The deadline for room reservations is February 21, 1997**. The preferred rate will be extended to CMS members on a space available basis after February 21.

Meeting Registration

Please submit a registration form by Februrary 21, 1997, if you plan to attend this Interim Meeting. We're delighted to receive it by mail, fax, or phone. We can check you in more quickly and efficiently if you've preregistered, in addition to providing more accurate and therefore cost-saving guarantees for our food functions. Thanks!

Messages

The hotel's phone number is 303-695-1700. (You may want to leave this number with someone.) If you need to be contacted, ask the hotel operator to transfer the call to the CMS registration desk or CMS office.

What To Do

Complete this entire form and return it to Colorado Medical Society, by mail to: PO Box 17550, Denver, CO 80217-0550, by phone to: 303-779-5455 or 1-800-654-5653 or by FAX to: 303-771-8657.

This portion goes directly to the hotel

Hotel Reservation Form

Colorado Medical Society
Interim Meeting
March 8-9, 1997

Please Reserve _____ Rooms for _____ Person(s)

Name _____

Firm _____

Address _____

City/State _____ Zip _____

Will arrive on _____
Day Date Time

Will depart on _____
Day Date Time

Credit Card _____
Name Number Exp. Date

Type Room—

Single 1 person	$68
Double 1 Bed 2 persons	$68
Double 2 beds 2 persons	$68
Suite	$125

Extra Charge per person _____

No. Persons Adults _____

Children _____

Check One

❑ 6 pm ❑ Guaranteed

Estimated time of Arrival at Hotel _____ Sharing with _____

Current lodging tax is 11.8%. Group cutoff date is 2/21/97. Reservations will be held until 6:00 pm Denver time, unless accompanied by a first night's deposit or guarantee of payment to a major credit card (please include expiration date). CHECK IN TIME IS 3:00 PM, CHECK OUT TIME IS 12:00 NOON.

Return form to: Holiday Inn
Attn: Reservation Department
3200 S. Parker Rd., Aurora, CO 80014

FAX: 303-745-6958

Or Call: 800-962-7672

DON'T MISS THIS CONFERENCE!

Caring for Colorado's Underserved

Sponsored by the Colorado Medical Society

Caring for Colorado's Underserved will be the most important forum to date on problems and solutions to providing care to Colorado's medically indigent population. It is an opportunity to learn from and give recognition to those doing innovative work, get excited about access to care, and identify strategies to increase indigent access to the health care system. This ***free*** conference also offers a time to develop system-wide solutions for responding to the changing health care environment as it effects care for the medically indigent (MI).

Colorado Medical Society has invited MI providers, hospitals, managed care organizations, legislators and foundations to ensure a lively dialog.

Plan to attend the dinner (no admission) keynoted by Jack Lewin, MD. Dr. Lewin is the Executive Vice-President/Chief Executive Officer of the California Medical Association. He served as Hawaii's Director of Health from 1986 to 1994. An ardent supporter of Hawaii's nationally recognized health care system, which is based on mandated employer coverage, Dr. Lewin gained high visibility during the Clinton Administration's efforts to revamp the health care delivery system. You will find his discussion about the role of community both interesting and motivating.



Dr. Lewin

Caring for Colorado's Underserved, March 7, 1997

8:15 -	8:45 am	*Understanding the Problem: Who are the medically underserved?*
8:45 -	9:30	*Challenges for MI Providers*
9:30 -	10:30	*Innovative Models of Care*
10:30 -	11:00	Networking Break
11:00 -	12:00 pm	*Breakouts* (4 concurrent sessions) a) financing models b) rural issues in indigent care/access c) legal ramifications/administrative issues d) special populations
12:00 -	1:00 pm	Lunch
1:00 -	2:15	*The Changing Health Care Environment: Managed care initiatives/ hospital mergers and the ramifications for care to the medically underserved*
2:15 -	2:30	Break
2:30 -	3:15	*Current Events: Pertinent legislation*
3:15 -	5:15	*Identifying the Direction for Colorado: Where do we go from here?*
5:15 -	5:45	Cash Bar
5:45 -	7:45 pm	Dinner (forum summary at 6:20; awards at 6:45; speaker at 7:00)

Registration for this free event and dinner is **required**. Registration deadline on March 3, 1997. CMS members may register by filling out the Interim Meeting registration sheet on page 83 . All others must register by calling Ellen Stein at CMS at (303) 779-5455.

PUT THIS DATE ON YOUR CALENDARS AND PLAN TO ATTEND

Friday, March 7, 1997
8 a.m. to 5 p.m.
at the Holiday Inn Denver Southeast

Don't let them Suffer in Silence!

Talking to your patients about domestic violence: How to encourage them to talk to you

Abuse and battering by a loved one creates a sense of betrayal that results in an *inability to trust others*. This distrust may extend to the victim's physician. Your patients will be hesitant to talk to you but, it is important and helpful to ask questions when you suspect abuse.

Understand that, to a victim, when a doctor does not ask how an injury occurred, it is another sign that the violence must be the patient's fault and there is no help. Victims may not respond immediately and may not respond as you think they should, but you will have taken a very important, potentially life-saving step.

- **Ask in different ways**. Not all victims will respond to the same kinds of questions. Victims' perceptions of what constitutes abuse differ dramatically and many will not equate what is occurring with the term "abuse".
- Maintain eye contact (when culturally correct).
- **Assume that any patient can be a victim** of domestic violence and that batterers can come from any family or economic background. The three professions with the highest abuse rates are law enforcement, law and medicine.
- It is important for the physician to recognize that victims are more than objects of abuse. They are **survivors**.

If you do suspect violence - Listen to your patients. Assure them that help is available for both them and their abusers. Ask if they are currently safe and provide them with resource information. Talk to your patients about your responsibility to report the abuse to law enforcement if you are treating injuries which have resulted from that abuse. Remember that your patient may need time before she/he is ready to accept help.

First and foremost remember that **you do not have to fix the problem**. But you are in a unique position to help your patients by:

1) recognizing domestic violence;
2) treating the injuries; and
3) referring patients to sources of safety, advocacy and support.

This month's domestic violence insert gives you specific questions you can ask your patients if you suspect they may be involved in domestic violence. It also provides some clues as to how to identify domestic violence. Please tear out the insert and utilize this information.

For additional resource materials please contact Ellen Stein at the Colorado Medical Society Offices - 930-0414 or 1-800-654-5653.

PROJECT C.U.R.E.



"Saving lives through medical surplus"

To donate supplies or for more information on Project CURE please call: (303) 727-9414.

Project CURE is a nonprofit corporation that collects and distributes donated medical supplies and equipment to underdeveloped countries. Donations of supplies or equipment are often tax deductible.

Membership

Steady growth

The final 1996 quarterly report on membership has been published. The statistics show that last year was another good year for the Colorado Medical Society in terms of membership growth. As of December 1996, membership was at an all time high of 5,279.

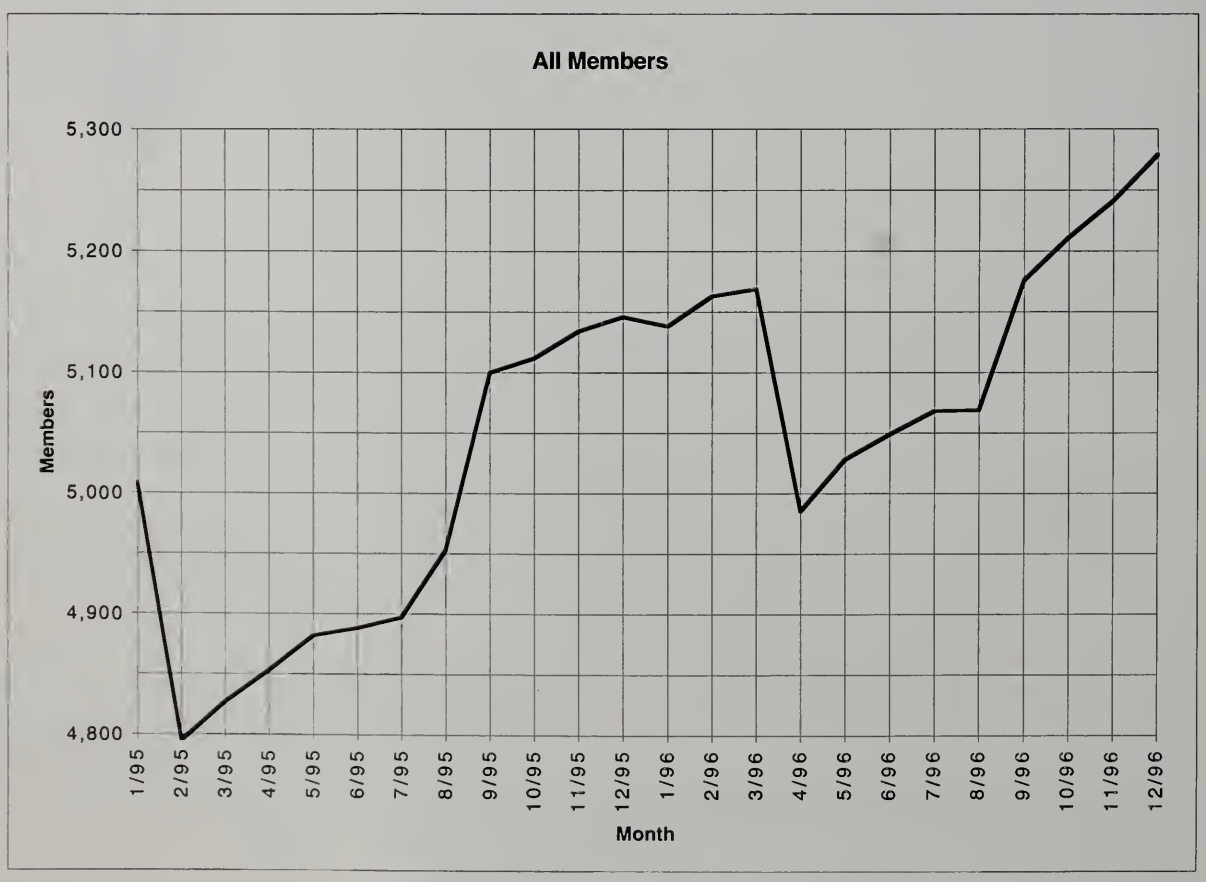
As the graph below shows, the final quarter of 1996 witnessed an almost two percent increase in membership when compared to third quarter statistics. The year ended with a 2.6 average growth percentage rate.

The average growth rate may initially appear unimpressive. However, one must consider that 184 members did not renew and were subsequently dropped in March of 1996. Given that fact, the 5.5 percent increase between April and December is noteworthy, thereby ending the year on a strong note.

Student membership grew by over 40 percent in the last quarter to finish at 107 members. These statistics are quite promising.

Active membership rounded out the year at 4,162. Dues exempt members and residents and students comprised the final 21 percent of total membership with 791 and 326 members respectively.

CMS continues to diligently serve the patient and physician community. Continued growth and support for the association is a primary goal for 1997.



1/16/97

CMS members appointed to department leadership at Children's Hospital

Children's Hospital (Denver) has recently appointed two Denver area CMS member physicians as department chairmen.

Fritz M. Karrer, MD, a pediatric surgeon, was named chairman of the Department of Pediatric Surgery.

Ken Winston, MD, a pediatric neurosurgeon, was appointed as the chairman of the Department of Pediatric Neurosurgery.

In other news, former CMS president William Carl Bailey, MD was replaced as the Director of the Burn Program at Children's by Lawrence L. Ketch, MD. Dr. Bailey retired after 34 years as an active member of the Denver medical community.

AHA reports more Colorado children are at risk for heart disease

The Colorado and Wyoming chapter of the American Heart Association recently reported that more Colorado children are at risk for heart disease because of obesity, lack of exercise and teenage smoking.

Local facts gathered from the 1995 Colorado Risk Behavior Survey (a statewide survey of students in grades 9-12) include:

- more than one-third (39 percent) are trying to lose weight;
- 59 percent of students do not attend physical education on a daily basis;
- 71 percent of all students said they had tried cigarettes and 34 percent have recently smoked.

For more information call (303) 369-5433.

CMS WIM section to address public health services

Margaret Cary, MD MBA MPH, Regional Director of the U.S. Department of Health and Human Services, will speak at the Women in Medicine Dinner and Business Meeting. The meeting , entitled *Public Health Services--A model of health care delivery* will be on Wednesday, March 5, 1997 at 6:30 p.m. at the CMS offices. It will be held in conjunction with the 1997 CMS Interim Meeting.

Dr. Cary has spoken on numerous occasions regarding health care reform and served as an advisor on health care issues to the President during his campaign. She will describe how Public Health Services is working for the underserved through their community clinics.

Dr. Cary is the first physician to be appointed to the position of Regional Director of US Dept. of Health and Human Services. Prior to her appointment, Dr. Cary had a private medical practice in Denver, was President of Cary Communications International and taught clinical medicine at the University of Colorado School of Medicine.

For more information, please call Cindy Wooley at (303) 930-0419.

CFMC to hold outcomes measurement conference

The Colorado Foundation for Medical Care will hold a must attend program entitled *Outcomes measurement: Putting it into practice* on March 12, 1997. This CME course is designed for practitioners and professionals who have the responsibility to teach or implement the operational phase of outcomes measurement. Data collection and interpretation, featuring the SF-36/12, will be addressed as tools a physician can use in the process of quality improvement. Attendees willcomplete the SF-36 to provide first-hand experience with the questions and process.

Objectives include:

- developing a plan of action for patient-based assessment in one's own setting;
- identify opportunities to improve physician-patient relationships; and
- use outcomes measurement tools for quality improvement.

A long list of experts in the field will address outcomes measurement issues. This activity qualifies physicians for one point COPIC credit, 5.5 hours of Category 1 credit toward the PRA of the AMA, and 5.5 hours of Category 1-A credit.

Attendance is limited. Registration deadline is March 5. The program costs $20. To register, or for more information please call Mary Fletcher at CFMC at (303) 695-3399.

Classified Advertising

Publication of any advertisement in ***Colorado Medicine*** *is not an endorsement by the Colorado Medical Society of the product or service.* ***Colorado Medicine*** *magazine is the official journal of the Colorado Medical Society, and is authorized to carry* ***General Advertising.***

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INTERNAL MEDICINE – A variety of internal medicine opportunities are available, through Lutheran Health Systems in northeastern Colorado. Community sizes vary from small to large. Competitive benefit packages, excellent educational systems, a a variety of recreational opportunities are available. Strong medical staff and complete hospital services in the region. If interested, please send your CV to: Sherry Kozero-Roth, North Colorado Medical Center, 1801 16th Street, Greeley, CO 80631: or fax (970) 350-6644. 02/0197

FAMILY PRACTICE – A variety of family Practice opportunities are available through Lutheran Health Systems in Northeastern Colorado. Community sizes vary from small to large. Competitive benefit packages, excellent educational systems, and a variety of recreational opportunities are availabe. Strong medical staff and complete hospital services in the region. If interested, please send your CV to: Jan Mesar, McKee Medical Center, PO Box 830, Loveland, CO 80539-0830; or fax to (970) 635-4066. 02/0197

FORT COLLINS: Established practice needing BC/BE family practitioner with obstetrics background. Competitive salary/benefits for the area. Send CV to : Alpine Family Care, 1014 Centre Avenue, Fort Collins, CO, 80526 or call: 970-482-8881 fax: 970-482-3253.
04/1196

PHYSICIANS, PSYCHIATRISTS and clinical psychologists, several positions are currently available for your specialty. As an independent contractor you will set your own schedule. A good supplemental income can be expected. Current Colorado state license in good standing required. Please forward a letter of introduction and a convenient time to call to: Colorado Medicine, PO Box 17550, Denver, CO 80217-0550, ATTN: Box 6. 02/0197

CENTRAL DENVER family physician outgrowing current office space. Looking for office/practice alternatives. Reply to Colorado Medicine, P.O. Box 17550, Denver, CO 80217-0550, ATTN: Box 5.
02/0197

Liberty Healthcare Corporation

FAMILY PRACTICE CAREER opportunities-Southwest Kansas-Liberty Healthcare Corporation seeks physicians for both Directorship and Staff level openings with our dynamic Family Practice clinic in Dodge City, KS. We offer a generous compensation package that exceeds most and includes: relocation assistance, seven weeks paid time off, paide malpractice, CMS stipend and more. For more information contact Ian Castronuovo during business hours at 800-331-7122 or our 24 hour voice mail: 610-617-3699, ext. 161. EOE (1N) 01/0297

2 ORTHOPEDIC SURGEONS NEEDED to join multi-specialty practice located 20 mi. north of Denver. Well established with strong family practice referral base. Send CV to Lori Spahn at 1925 West Mountain View Ave, Longmont CO 80501 or call 303-651-2373. 01/0297

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LOCAL LOCUMS is a Denver-based medical practice dedicated to providing quality locums coverage to Colorado family doctors. If you need to be away from your office or want to expand your practice without the risk and expense of hiring a new partner, we'd be happy to talk to you about how we can help. Please call Dr. Sheldon or Dr. Sowell for more information at (303) 370-6977.
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◆ *MISCELLANEOUS*

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ALPACAS ONE OF MOTHER NATURE'S FAVORITE FARM ANIMALS. THE FINEST LIVESTOCK INVESTMENT IN AMERICA. CALL DR. HELEN DANAHEY 719-275-2701. 06/0996

Don't let them Suffer In Silence!

For additional resource materials, contact Ellen Stein at the CMS offices.
(303) 779-5455 or 1-800-654-5653 or E-mail *Ellen_Stein@cms.org.*

A Unique Fringe Benefit For CMS Members



Buying or Leasing a New Car???

The **Colorado Medical Society** now provides a professional fleet management service to assist members throughout the state when purchasing or leasing a new vehicle. This service provides valuable vehicle information such as factory invoice costs, available options, technical data, consumer reports, etc.

Once your selection is firm, your purchase or lease will be arranged at **prices normally available only to large corporate fleets**.

Colorado Medical Society has endorsed Rocky Mountain Fleet Associates as a CMS member service, based on the satisfaction of the many physicians who have used their services over the past several years. These physicians have reported excellent results, **usually with savings of more than $1000 from even the best negotiated showroom price**.

For more details, call **(800) 864-4388**. In Denver, **753-0440**.

Colorado Medical Society

RUMINATIONS

(**def:** chewing again what has been chewed slightly and swallowed; to **REFLECT**)

*by **Bill Pierson**, Managing Editor*

"An enviro-mechanical phenomenon caused by. . . tailgating drivers. . ."

I have it! I finally figured it out!

I thought for the longest time (well, the past three years, at least) that automobiles were breeding and multiplying right out there on the streets and highways. I figured that this must be an *"enviro-mechanical"* phenomenon caused by the thousands of "tailgating" drivers. I have decided I was wrong.

The world is so crammed with people, information, systems, links, warps, RAM, ROM and hyper-accelerators that people are willing to do anything to find their own "space." The automobile is increasingly representing individual space to people besotted with the electronic revolution. There, in the confines of your own "cockpit", so to speak, you can turn on or off the radio, there is no television, there is no computer screen (at least, not in the usual cathode-ray tube [CRT] configuration) for you to stare at and on which you have placed the virtual responsibility of turning our earthen globe. Yes, we know there are computers of all sorts inside the workings of the auto, but that is all right because they need not be tended. We can get away from it all.

We can smoke and, even more careless than our daily driving would indicate, we can use alcohol or other stupefying liquids or substances while careening down the highway in "our space".

I have already expressed my feeling about people who drive and yak on the telephone, all the while changing lanes, turning corners, even attempting to park, and certainly while in the fast-food drive-throughs.

Therefore, it is my firm conclusion (now) that the reason there seems to be so much more traffic on the streets at all times of the day and night, weekends and holidays included, is that people are fleeing to their vehicles. The automobile or motorized vehicle is the only place millions of people can find their own space, their own isolation, as it were. I can appreciate their feelings. There is little space left on the planet for true isolation or wilderness. The cellular phone works as effectively in the outback as it does downtown. Jet travel is no longer limited to the "haves" of the world. It is there for everyone, and quite often at bargain prices. Therefore, everyone is engaged in this wild and crazy frenzy to do whatever they are doing at the moment. It may be only looking for a way to avoid preparing a meal for themselves or their children.

Why are we in such a hurry to get our lives over with? I felt pushed the other night because I had an engagement, but there was something I wanted to do on my computer before I met with these people. When I got into the computer and it didn't respond as quickly or in quite the way I wanted, I became perplexed. Know what happened next? Of course you do! The computer froze in its tracks, and three days later it was still frozen. What good did all this hurry-up, "have to have it now" treatment of what was **not** a problem get me in the end? It got me a **real problem,** and I am certain that whatever it was I tried to force my computer to do in a hurry was the cause of the whole mess.

But I have been shaped by the "new age" communications revolution; I expect my computer to do all these whiz-bang things, and at supersonic speed!

I thought for some time that the great increase in automobile traffic was due to the large number of smokers who have been driven out of their homes and their work places. The majority of them just drive around and smoke. I still think that accounts for a large percentage of the drivers on the road. However, the increases have now taken on a new dimension.

We probably don't have any great increase in the **net** number of vehicles on the road; the **gross** *"enviro-mechanical"* phenomenon is simply the flight of people to their cars, seeking a personal space which they think they control.

STACKS

COLORADO MEDICINE

"Advocating excellence in the profession of medicine"

Volume 94, Number 3

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A quite day at Stout Street Clinic in Denver

the problem of the medical indigency strictly an urban problem? Not according to the registration for olorado Medical Society's 1st Annual Conference on Care for the Medically Underserved. Over 200 per-ons from across Colorado registered for this day-long conference, held in conjunction with the CMS In-erim Meeting in Denver, March 7-9, 1997.



Ed Farrell, MD
Medical Director
Stout Street Clinic



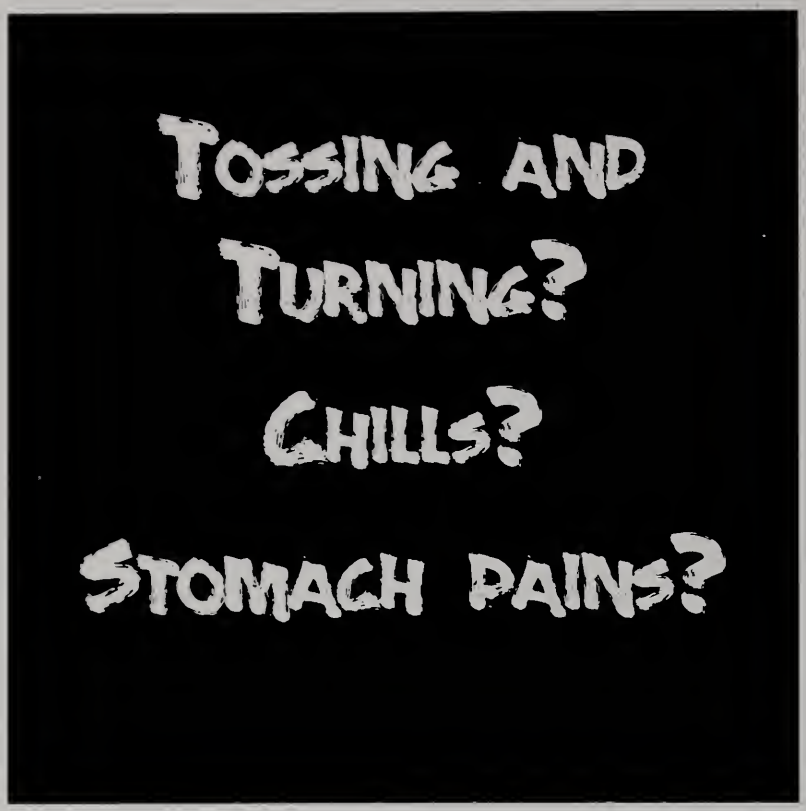
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This Issue:

The Patient Is #1: the patient-physician covenant by M. Ray Painter, MD ..... **page 97**
What's In A Book? Denver Medical Library by John L. Lightburn, MD, Historian ..... **page 111**
Leaving The Bedside? Should you take the plunge? by Leigh Truitt, MD ..... **page 118**
Drug Interaction Software: What is it? by Michael Victoroff, MD ..... **page 120**



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COLORADO MEDICINE

March, 1997 Volume 94, Number 3



Cover Story

Often overlooked and rarely overserved, the medically indigent of Colorado represent a growing population of patients. Medical indigence is a complex issue, but there are solutions.
See pg. 116.

DEPARTMENTS

97 President's Letter
99 Executive Director's Update
103 The Lobby
107 Copic Comment
108 Health Care Financing
111 Archives
114 Board Highlights
115 Colorado Physician Network
124 Medical News
128 Classifieds
130 Ruminations

In This Issue...

97 **The patient is #1:** Thoughts on how physicians can strengthen and maintain their covenants with patients.
by M. Ray Painter, MD, President Colorado Medical Society

104 **Poverty and disease: a postcard from the edge.** How does disease and death relate to economic and social status? A provocative analysis of how health is affected by and may be attributable to certain factors.
by Deborah Baker, Ph.D

108 **Lost insurance claims, or delayed payment?** Help CMS help you to stop this growing problem.

111 **What's in a book?** Learn how pioneering physicians founded and maintained the medical treasures which helped create today's Denver Medical Library. Trace the history and motivation of those who believed that you can't judge a book by its cover.
by John L. Lightburn, MD, Historian Colorado Medical Society

118 **Leaving the bedside? - Yes or no?** Are you wondering if you should take the plunge and move outside of clinical medicine?
by Leigh Truitt, MD

120 **Drug interaction software**: What is it, and why do you need it?
by Michael S. Victoroff, MD, Chair CMS Committee on Medical Informatics

122 **Medical savings accounts**: Your cure for rising health care costs?

Special Insert
Dr. COG: Resource Directory

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M. Ray Painter, MD
President, 1996 - 1997

The Patient is #1

Everyone would like to be distinguished as being number one at whatever they do, or whomever they are. We all need and enjoy being regarded with importance. Physicians are the same. However, when we took our oaths, we vowed to subjugate those desires to a higher purpose. Our patients' needs come before our own. The patient is the reason why we exist; the patient must be number one.

Ensuring the highest possible care for our patients must continue to be a priority. We were trained to provide high quality care, and we must not let anything stand in the way of administering that care. We must also strive to make patients feel that they are number one and that quality is our goal.

Unfortunately, preserving this priority is challenging in today's changing health care system. You might say that "loving your patient and having total compassion for their problems" is sometimes as difficult as petting a porcupine.

There are many reasons for a breakdown in the patient-physician relationship. Patients are more knowledgeable, more distrustful and more demanding for many reasons. Specialization requires visits to new doctors for short periods of time. Mobility in our society transplants patients to new areas where they are unfamiliar with local physicians. As a result, the familiarization created by numerous encounters, which is necessary to create a trusting relationship between patient and physician, is not being established. The government, politicians and others have successfully driven a wedge into the patient-physician relationship. In some instances contract medicine may force patients to visit certain physicians when they prefer to go elsewhere. The list seems endless.

Physicians face additional dilemmas. Sometimes contracts do not permit doctors the latitude in treatment as they would prefer, or may not reimburse physicians at the level which we feel is "fair". Some types of contractual medicine utilize productivity quotas, which create restraints on the time requirements of some patients. Physicians may have to increase their workload to compensate for decreased payment for services. The trend toward a spiraling decline in income has also provoked concern regarding career longevity among some physicians.

All of these issues place a strain on the patient-physician relationship. It would be easy for us to use them as an excuse to take out our frustrations on the next patient. We need to constantly guard against this tendency.

Today physicians are barraged with reminders that medicine is a business, not just the provision of a service. Even so, every business must have a mission statement. Our mission statement should be "to provide the highest quality, most personalized, friendly and timely care to every patient we see". Certainly one of our goals should be to be ensure that the patient is happy, satisfied and is treated with dignity and compassion.

I repeat, nothing should stand in the way of quality care for our patients.

"Nothing should stand in the way of quality care for our patients."

That is part of the professionalism that we signed into when we decided to be a physician, it's part of the training that we all received, and it should be part of the commitment that we continue to not only profess but to practice.

There is a bonus to the reaffirmation of our commitment to the patient and quality professionalism. The consumer will eventually control any free market system, which means that patients will eventually control the health care system. A patient's request or problem and a physician's response spends 75-80 percent of the health care dollar. That represents clout and should represent control. The partnership between patient and physician is the crux. A professional and concerned physician, and a trusting and appreciative patient can, should and will reestablish control of the delivery of health care.

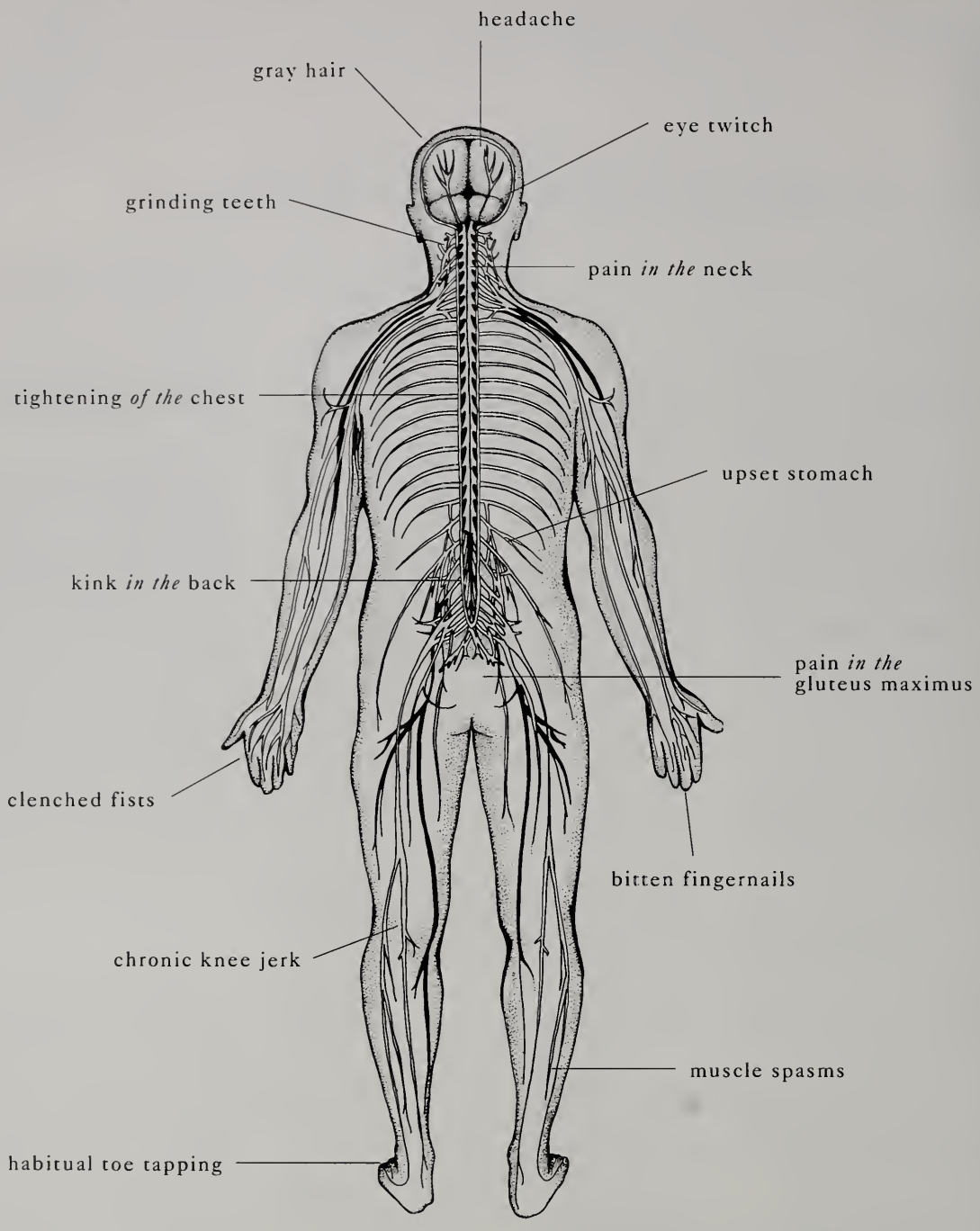


Figure 23

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...a compilation of medically-related news briefs of immediate interest to the physician community occurring after ***COLORADO MEDICINE*** has gone to press. ***AT PRESS TIME...***

CMS Med Fax®
by Montgomery Little and McGrew, P.C.
legal counsel to the Colorado Medical Society

Medical licenses Expire May 31

Renewal package in the mail

All Colorado licenses will expire May 31, 1997. Your renewal application will be sent to your "address of record" on file with the Board of Medical Examiners. If you have moved from the location where you last received the Board's newsletter, you must send your change in writing to:

Colorado Board of Medical Examiners
1560 Broadway, Suite 1300
Denver, CO 80202
Phone: (303) 894-7690
Fax: (303) 894-7692

By law, only **one** renewal notice will be sent to you.

After you receive your renewal packet, complet and sign all forms and use the envelope provided which goes directly to the depository.

The BME has implemented new processes and procedures for physicians whose licenses are currently inactive or lapsed. If you currently hold an inactive or lapsed license and plan to activate it, it is important that you contact the BME.

If you have questions about the renewal please contact the BME at (303) 894-7690.

Medical, legal and moral concerns surrounding dying patients to be addressed

Dr. Ira Byock, nationally recognized expert in hospice care, will make a number of presentations to hospital staff and the public on the medical, legal and moral concerns surrounding dying patients and their families. Author of the book *Dying Well*, Dr. Byock received the National Hospice Organization Person of the Year Award in 1995.

He will present Grand Rounds to medical staff at St. Anthony's Hospital in the new Cardiac Center at 7 am on April 17, and at St. Joseph's Hospital in the new conference center at 7 am on April 18. Both programs carry 1 hour of CME credit.

Dr. Byock will also make a public presentation on April 17 at 7 pm at St. Anthony's Hospital Heart Center Auditorium.

Please call the CMS Communications Department at (303) 779-5455 or 1-800-654-5653 ext. 2425 for details.

1997 CMS Leadership Conference to focus on outcomes

The 1997 CMS Leadership Conference will be held on May 31-June 1 at the Sonnenlap Resort in Vail. CMS President-elect Gary VanderArk, MD, will assist to-be-announced speakers in exploring outcomes measurements.

This rapid growth and importance of outcomes measurements will affect every physician in the coming years. Outcomes will undoubtedly increase the quality of clinical care. Managed care companies have shown great interests in these measurements, and are currently attempting to utilize them as grading reports for member providers. Doctor stats on forms similar to baseball trading card may be the next phase in reporting health plan performance. The conference is a must attend for all CMS members.

Look for registration and program details in next month's edition of *Colorado Medicine*.



Med Fax: Medico-Legal News

by Karen B. Best, Esq., an associate with the law firm of Montgomery Little & McGrew, P.C.
This column contains information concerning topics of general interest in the medical-legal field. For further information or help with specific problems, please contact Montgomery Little & McGrew, P.C.

Immunity from liability for professional review activities: Can you count on it?

*by Kevin J. Kuhn**

Brown v. Presbyterian Health Care Services, a recent United States 10th Circuit Court of Appeals decision, undermines immunity for peer review participants in peer review proceedings.

Dr. Brown was a family practice physicians in Ruidoso, New Mexico. She practiced at Lincoln County Medical Center. As a family physician she also practiced obstetrics.

A competitor, obstetrician-gynecologist Dr. Williams, raised concerns in a peer review setting about the quality of care Dr. Brown provided to obstetrical patients. As an outgrowth of this initial review, Dr. Brown agreed to consult with an obstetrics specialist when treating high-risk obstetrical patients.

Later, the hospital became concerned that Dr. Brown wasn't living up this requirement to obtain consultation. The hospital initiated peer review proceedings, concluded Dr. Brown had violated the agreement, and revoked her staff privileges. In their report to the National Practitioners Data Bank, the hospital erroneously characterized the action against Dr. Brown as one for "incompetency/malpractice/negligence," although the only finding was that Dr. Brown hadn't honored the consultation requirement.

Dr. Brown sued the hospital, the hospital administrator, Dr. Williams and others. The defendant peer review committee members filed motions attempting to secure their dismissal from the case before trial on the grounds that they were immune, as a matter of law, from damages resulting from the revocation of Dr. Brown's obstetrical privileges under the Health Care Quality Improvement Act (HCQIA). However, the trial court disagreed and denied their motions. The defendants remained in the case. In a three week jury trial, Dr. Brown succeeded on her claims for defamation, tortious interference with contract, and some of her antitrust claims.

The defendants asserted on appeal that the trial court was wrong when it denied their motions for dismissal under the HCQIA's qualified immunity provision. The HCQIA is federal legislation which recognizes that "the threat of private money damage liability...unreasonable discourages physicians from participating in effective professional review." Congress therefore decided it was essential to provide "qualified immunity" from damages actions for hospitals, doctors and others who participate in professional peer review proceedings.

"Qualified immunity" is not "absolute immunity;" in other words, the person claiming qualified immunity must prove that he or she has fulfilled all requirements which would entitle that person from a lawsuit. On the other hand, for example, judges performing their judicial functions generally enjoy absolute immunity from monetary civil damages arising from their decisions rendered in cases.

A peer review participant is immune from private damage claims stemming from a peer review action provided the review action is taken:

1) in the reasonable belief that the action was in the furtherance of quality health care;
2) after a reasonable effort to obtain the facts of the matter;
3) after adequate notice and hearing procedures are afforded to the physician involved or after such procedures as are fair to the physician under the circumstances; and
4) in the reasonable belief that the action was warranted by the facts known after such reasonable effort to obtain facts and after meeting the requirement of paragraph (3).

The 10th Circuit held that if the aggrieved physician in a peer review process can demonstrate that any one of the four HCQIA statutory requirements has not been satisfied *beyond dispute*, then qualified immunity will not attach, and the peer review participant will not be dismissed from the case before trial on the basis of a qualified immunity.

Dr. Brown submitted evidence from her expert, a Dr. Lindley, that Dr. Brown had properly obtained appropriate obstetric consultation when necessary. The court held that evidence was enough to defeat the qualified immunity protection because the evidence *called into question* whether the peer review participants had made a "reasonable effort to obtain the facts."

The hospital and other defendants argued unsuccessfully that a difference of opinions among experts does not raise an issue as to the objective reasonableness of the inquiry. The court disagreed: "Under its theory, a peer review participant would be absolutely immune from liability for its actions so long as it produced a single expert to testify the (four requirements listed above) were satisfied. This would be in direct contravention to Congress' intention to provide 'qualified immunity'".

(Continued next page)

(Immunity continued)

This opinion is significant. Whenever possible, attorneys attempt to have their clients dismissed through pre-trial motions. This case makes a pre-trial dismissal more difficult to obtain. It will also expose the peer review process and its participants to litigation by the aggrieved physician when he or she can provide expert testimony at odds with that presented by the hospital. As the court noted: "In determining whether a peer review participant is immune under (HCQIA), the proper inquiry for the court is whether Dr. Brown has provided sufficient evidence to permit a jury to find she has overcome, by a preponderance of the evidence, any of the four statutory elements required for immunity under (HCQIA)". This ruling takes the determination of whether qualified immunity applies to the peer review participant outside the realm of a pre-trial proceedings and, except in the clearest of cases, places the question in the hands of the jury.

Of significance in the Brown decision is that Dr. Williams and the hospital administrator, who were not the decision makers on the privileges issue, were also subject to suit because "they were the catalysts behind, or played a crucial role in, every step of the proceedings against Dr. Brown."

This case offers encouragement to the aggrieved physician adversely affected by the peer review process, and discouragement from participation in peer review proceedings by others, at least in terms of analysis of protections and immunities offered by HCQIA. It should be noted that his decision did not reach or address state laws governing peer review processes.

What does it all mean? Physicians participating in peer review activities must ensure that all the steps are followed before any adverse action is taken against a physician. Even then, if the participant is sued, there are no guarantees that the participant will be let out of the lawsuit before a full-blown trial. Unfortunately, the practical effect of rulings such as this which whittle away at immunity may be to discourage participation in professional review activities.

**Kevin Kuhn is a shareholder with Montgomery, Little & McGrew, P.C., who represents physicians, hospitals and other health care providers in professional malpractice cases an in administrative matters before the various boards. He also represents lawyers in professional negligence lawsuits, and lends his talents to a myriad of other legal matters.*

Colorado Medicare Carrier Awarded Six New States

Blue Cross and Blue Shield of North Dakota, the Medicare Part B Carrier for Colorado, was awarded a contract to process Part B claims for six additional western states - Alaska, Arizona, Hawaii, Nevada, Oregon and Washington. The processing for these new states will be phased in beginning June 1, 1997, with the final transition scheduled for August 11, 1997.

The claims entry for these states will be done in North Dakota, while their beneficiary calls will be handled here in Colorado. This means Blue Cross and Blue Shield of North Dakota will be hiring additional staff at both locations to handle the increased volume. This also means that both the Colorado office and the North Dakota office will be moving into larger facilities. The Colorado staff is scheduled to move into their new office (730 Simms, Lakewood) early in May.

The Carrier will make every effort to ensure that the impact on Colorado providers is minimal. CMS staff will stay in contact with the Carrier to monitor their progress. If you encounter any problems, please contact Marilyn Rissmiller at 779-5455 or 1-800-654-5653, extension 2428.

CMS Med Fax

Colorado Medical Society provides the following listings of events as a member service only. Some events are approved for Continuing Medical Education credits. Information is provided by the sponsoring organizations. For more details, use the telephone contact at the end of the listing.

American Lung Association
16th Annual Big Sky Pulmonary & Critical Care Med. Conf.
March 20-22, 1997
Big Sky, Montana
(406) 442-6556

The Prosper Meniere Society
6th Symposium and Workshops on Inner Ear Medicine and Surgery
March 22-29, 1997
Aspen, Colorado
Contact: Jane Wells, (303) 788-4235

Colorado Dept. of Public Health & Environment
HIV Prevention Counseling
April 16-17
Pueblo, CO
Contact: (303) 692-2740

Colorado Hospital Association
The Paper Chase: Fundamentals of health care contracts
April 17, 1997
Denver, Colorado
Contact: (303) 758-1630

Dr. Ira Byock
Medical, Legal and Moral Concerns Surrounding the Dying Patient and Family
April 17, 1997
Denver, Colorado
1 hr. of CME credit
Contact: (303) 779-5455 ext. 2425

Colorado Dept. of Public Health & Environment
HIV Prevention Counseling
May 14-15
Denver, CO
Contact: (303) 692-2740

Colorado Dept. of Public Health & Environment
Managing Stress for STD/HIV Professionals
June 3, 1997
Pueblo, CO
Contact: Michael Murphy (303) 692-2766

Leigh Truit, MD, et al.
Leaving the bedside? Yes or no?
June 6, 1997
Denver, Colorado
Contact: Elizabeth Kraft at (303) 333-0900

The Given Biomedical Institute
Genetics Ethics in the 21st Century
July 18-20, 1997
Aspen, Colorado
Contact: Linda Woodstock at (303) 372-9050 or 1-800-882-9153

Colorado Society of Osteopathic Medicine
Annual Meeting
July 25-27, 1997
Vail, Colorado
18 hours AOA category 1-A CME and Physician Asst Crdt.
Contact: Patricia Ellis at (303) 322-1752

America College of Cardiology
11th Annual Echocardographic Symposium on 2-D and Doppler Echocardiography at Vail
July 27-31, 1997
Vail, Colorado
27.5 Category 1 AMA CME credit
1-800-253-4636, ext. 695

Send us your calender items.

If yourr specialty society or hospital is sponsoring a CME event or seminar which would be of interest to physicians in Colorado, have them send the information to: Event Calender, *Colorado Medicine*, P.O. Box 17550, Denver, CO 80217-0550. Please include information detailing program sponsor, date, location and phone number for more information.

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Executive Director's Update



Sandra L. Maloney
Executive Director
Colorado Medical Society

At a recent Colorado House of Representative's Committee on Health, Environment, Welfare and Institutions (HEWI), Dr. Gene Sherman, chair of the CMS Managed Care Task Force, was testifying on behalf of CMS to express our support of a bill introduced by Representative Marcy Morrison. The title of the bill is "Concerning Consumer Protection Standards for the Operation of Managed Care Plans." Essentially this bill: 1) incorporates consumer protections in the creation and maintenance of provider networks by health insurance carriers; 2) establishes standards to assure the adequacy, accessibility and quality of health care services offered under managed care plans; 3) establishes requirements for written agreements between health insurance carriers and health care providers participating in managed care plans; and 4) makes the violation of this act an unfair method of competition and unfair or deceptive act or practice under current insurance laws. All of these issues are clearly supported by CMS and indeed, are already a part of the CMS Managed Care Policy. We would be terribly remiss if we had not supported this bill.

During Dr. Sherman's testimony, a member of the HEWI Committee stated that he read the monthly issues of the *Colorado Medicine* from cover to cover. He went on to say that most of articles were negative towards health maintenance organizations. He then asked Dr. Sherman if there was any HMO that the Medical Society "liked".

It is not a matter of "like" or "dislike". As in any industry or profession, there are good and bad. There are HMOs doing business in Colorado that are very easy to work with, very willing to help CMS resolve problems and proactively prevent future problems. There are others that don't even care to establish an open line of communication.

Over the past several years, CMS has made great strides in its attempt to work closely with the Colorado HMO Association (CHMOA) and individual HMOs. CMS recognizes that managed care is here to stay. However, it is our role to represent the interests of our members.

The following are but a few of activities CMS has undertaken. It should be noted that CHMOA is well aware of, and participates in, a majority of these activities.

- Created the Colorado Physician Network which has joint ventured with Rocky Mountain HMO to establish a managed care plan (Rocky Mountain Physicians Choice), that is run by physicians with the health of its members as priority one.
- Worked jointly with CHMOA to establish the managed care "White Paper" on physician affiliation and disaffiliation.
- CMS hired a physician consultant to work directly with HMOs on various topics, and to help member physicians who were experiencing difficulty with HMOs.

(Continued next page)

It is not a matter of "like" or "dislike".

(Continued from previous page)

- Formed a coalition with consumer groups.
- Created the CMS/CHMOA Joint Committee which meets bi-monthly.
- Created a CMS/CHMOA Continuity of Care Subcommittee.
- Created a CMS/CHMOA Medical Records Subcommittee.
- Created a CMS Managed Care Task Force.
- Participate in the activities of the Rocky Mountain Center for Health Care Ethics.
- Revamped the CMS Department of Health Care Financing to better meet the needs of CMS members and establish better lines of ongoing, open communication with managed care organizations.

I am sure I have left out some activities, but this list alone is pretty impressive. Again, it's not a matter of "liking" any given HMO. I feel it is more a matter of being able to work together honestly and openly. CMS is really trying to work cooperatively with all HMOs. Yes, there are times when we get frustrated. The HMOs probably do too.

I have a lot of respect for the Representative who asked the question of Dr. Sherman in the HEWI Committee. He is straightforward and you can count on him to say what's on his mind. He, along with others, probably feels that CMS comes across as being anti-everything when it comes to managed care. Not true. I hope this article will shed some light on the types of activities we are undertaking, and demonstrate that CMS is trying to work cooperatively with others. We have more progress to make, but we've come a long way in the past few years; and yes, there are times when all parties will simply have to agree to disagree.

LEGAL UPDATE

from Gelt, Fleishman & Sterling P.C.



A. Craig Fleishman, Managing Director

Protecting yourself after suit

Part II (Continued from last month)

You should not discuss your case with friends, family or other attorneys. A careless or supposedly humorous remark about your case can come back to haunt you later on. Any questions about who you can or cannot discuss the case with should be directed to your attorney. It is also important that you do not make admissions of fault or engage in conduct which could be construed as an admission of responsibility. Your statements or conduct may later be offered at trial as admissions of wrong-doing.

To support your case, your attorney will engage experts whose evaluation will provide the information necessary to make a decision on whether to defend the lawsuit or, if there is significant liability, to attempt to resolve it quickly through settlement. Of course, the claimants will find experts to support their position.

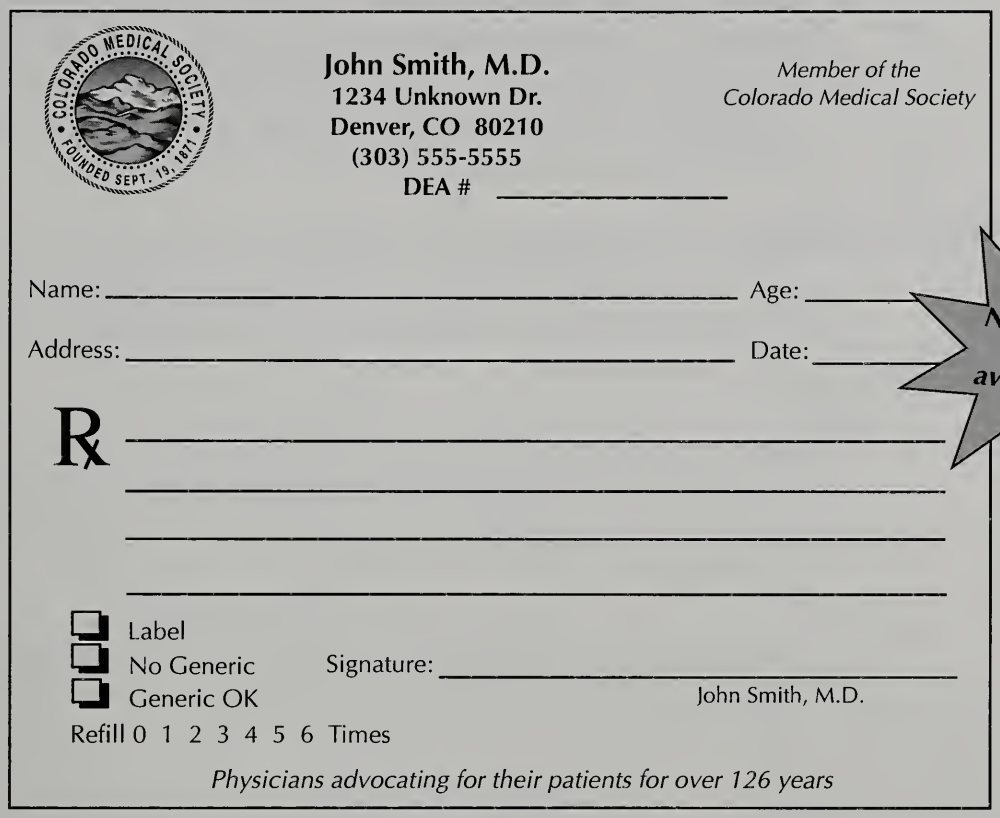
Through this fairly simple procedure, a considerable amount of information can be accumulated and analyzed and major litigation decisions made. Often claimants have legitimate claims but due to human nature, embark upon Cadillac repairs for Chevrolet problems or inflate their claims dramatically. This can result in expensive litigation because high expectations often result in the rejection of reasonable settlement attempts. Therefore, the quicker attorneys can evaluate a case, the quicker they can provide competent advice as to the reasonable settlement range of the case or whether the problem should be repaired or whether the claim should be defended.

Based upon this step-by-step procedure, your lawsuit can be quickly and effectively defended or resolved. Not only will your case be thoughtfully examined and decisions made based upon complete information, there will be no wasted or costly steps, and your attorney's fees should be minimized.

For further information contact:
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Here's Our Agenda

It's simple. It's straightforward. And it represents the future of medicine. The American Medical Association presented to the Republican and Democratic leadership this agenda for the upcoming 105th Congress. Your AMA membership strengthens our voice in support of physicians and their patients. . . and will enhance our efforts to turn these goals into reality.

- **Patient Protections** Above all, preserve the ability of physicians to act as advocates for their individual patients. Do not allow insurers to "gag" physicians or withhold medically necessary treatments from their patients.

- **Medicare Reform** Make the Medicare program solvent. Expand patient choice of plans. Allow future growth rates that cover patients needs. Retain special protection for the vulnerable and elderly.

- **Medical Education and Research** Continue to support medical education and research so we can find cures for killers such as AIDS and cancer.

- **Public Health Problems** Expand prevention and treatment programs to combat AIDS, drug abuse, smoking and violence. These problems cost billions of dollars and millions of lives.

- **Liability Reform** Enact meaningful liability reform to ensure fair compensation to patients with legitimate claims while eliminating excessive malpractice awards that lead to defensive medicine.

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American Medical Association

Physicians dedicated to the health of America

150 Years of Caring for the Country

1847 • 1997



by Richard Allen, MD,
Co-chair CMS Council on Legislation

The Council on Legislation has had an extremely busy year so far, reflected by the number of priority bills listed below. We are following 47 legislative proposals and have taken positions on 31 bills. Two bills were killed prior to action by the Council and 16 will be considered at the February 26th meeting. The deadline for submission of bills has passed, but legislators always have the opportunity to acquire late bill status which means there may still be some surprises waiting in the wings.

SB 5, Concerning Medicaid Managed Care, will place 75 percent of the state's Medicaid population in managed care plans by the year 2000. This bill is patterned after a similar 1996 proposal but contains a number of safeguards recommended by CMS last year. We are closely monitoring this bill.

Continued Operation of the Colorado Uninsurable Health Insurance Plan has our support. **SB 41** is currently in Appropriations.

CMS members helped voice the medical society's opposition to **SB 64** by providing expert testimony. Establishment of a Medical Fee Schedule for Services Provided Under the "Colorado Auto Accident Reparations Act" was subsequently killed on January 30.

SB 127, Concerning Health Insurance was killed on February 14. The bill would have repealed existing rate bands applicable to small group health insurance, while retaining rating requirements.

Limited Prescriptive Authority for Chiropractors (**HB 1017**) would have allowed chiropractors with some additional education to prescribe, administer and inject non-controlled legend drugs. CMS opposed this bill which was killed in committee.

Scope of Insurance Provisions Regarding the Treatment of Pain requires insurers offering managed care plans to disclose whether the plan provides coverage for treatment of intractable pain. CMS supports **HB 1104**.

We are working closely with other consumer groups to support Rep. Morrison's efforts in championing **HB 1122**. Consumer Protection Standards for the Operation of Managed Care Plans sets forth standards for the adequacy of managed care networks. CMS anticipates further opposition to this bill by managed care insurers.

HB 1139, Prescribing of Antibiotic Drugs, would amend the Medical Practice Act. Physicians would be guilty of unprofessional conduct if they repeatedly prescribed these drugs without clinical justification. CMS opposes this bill because it is totally unnecessary.

Procedure for Denial of Benefits by a Health Coverage Plan Pursuant to Utilization Review requires that physicians conducting utilization review be licensed in the State of Colorado. **HB 1161** is being supported per CMS policy.

The Alternative Medicine bill, officially known as Access to Health Care Options (**HB 1183**), broadens the standard of care for unprofessional conduct in the Medical Practice Act. Legislators have been beseiged by consumers in support of this bill. Repeated calls to action by CMS have had little effect on the lackluster opposition to this legislation by the physician community. We need your help, call the CMS Government Relations Departmentat (303) 779-5455 for details. The bill is currently in Appropriations awaiting further action.

"There may still be some surprises waiting in the wings."

Uniform disclosure of health plan information has gained legislative momentum with the introduction of **HB 1311**. Sen. Hopper is sponsoring Comprehensive Health Benefit Plan Description Forms with the strong support of both CMS and the consumer group Protect Colorado Health Insurance Consumers (PCHIC).

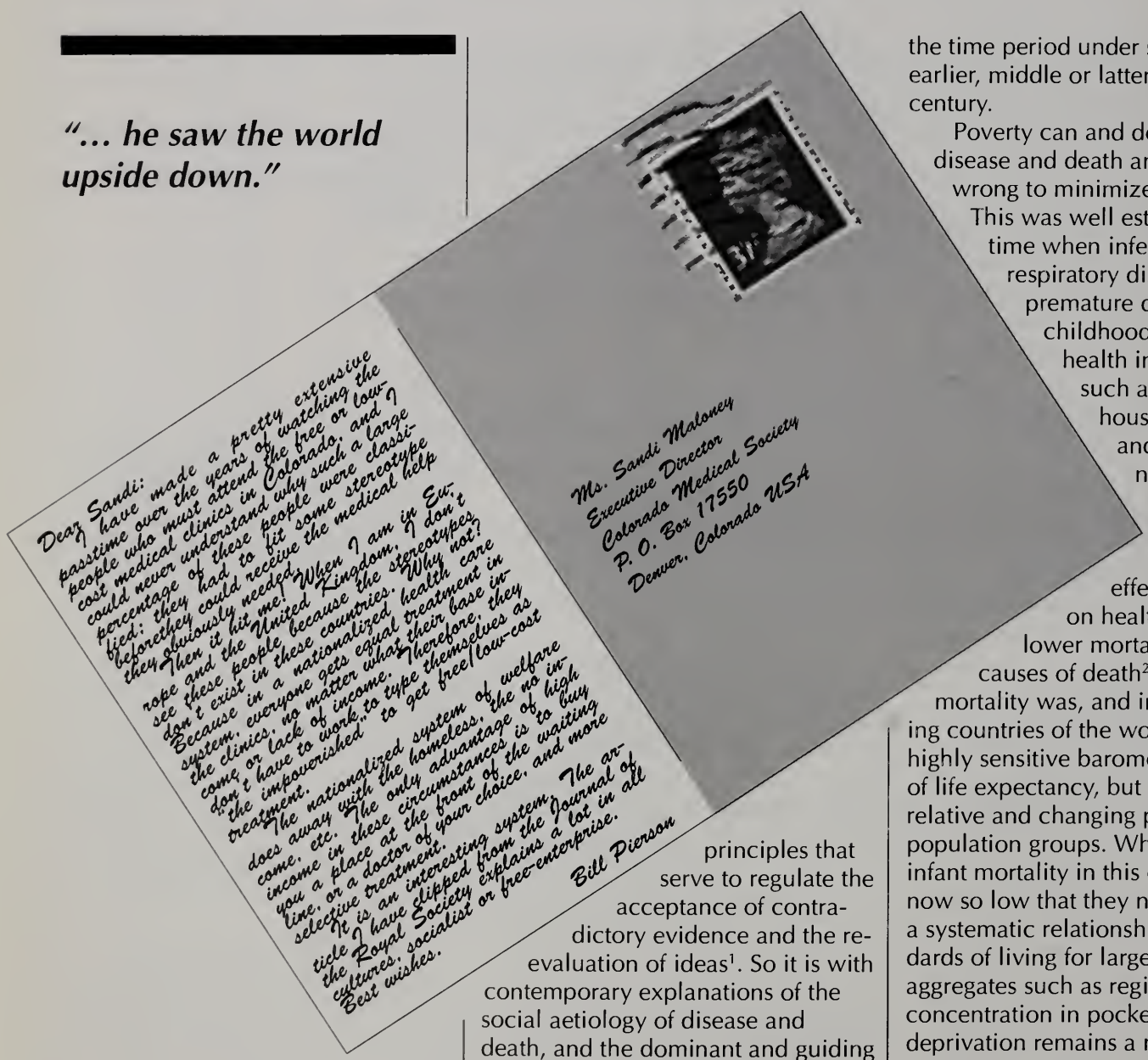
CMS members may receive copies of the Legislative Digest or specific bills by faxing your request to the CMS Department of Government Relations at (303) 771-8657. **Internet subscribers** can access legislative information by visiting the Members Only section of the CMS Home Page (http://www.cms.org). Select "Members Only Heard on the Hill" in the Members Only section for a current list of CMS legislative activity.

Poverty and disease: a postcard from the edge

by Deborah Baker PhD

Reprinted from the Journal of the Royal Society of Medicine -Volume 88, March ,1995

"... he saw the world upside down."



There have been many occasions in the history of scientific inquiry when propositions that have initially provided considerable understanding of a particular phenomenon, then become unbending principles that serve to regulate the acceptance of contradictory evidence and the re-evaluation of ideas[1]. So it is with contemporary explanations of the social aetiology of disease and death, and the dominant and guiding principle that it is poverty that causes worse health and earlier death. The principle seems to be applied whether populations are young, middle aged or old; whether they are male or female; whether they are aggregated by country, by region or by social class; or whether the time period under study is the earlier, middle or latter part of this century.

Poverty can and does cause disease and death and it would be wrong to minimize its effect. This was well established at a time when infectious and respiratory diseases caused premature death in early childhood. It was public health interventions such as improved housing, sanitation and a more nutritious diet that directly alleviated the devastating effects of poverty on health and led to lower mortality from these causes of death[2]. Thus, infant mortality was, and in the developing countries of the world, still is a highly sensitive barometer not only of life expectancy, but also of the relative and changing poverty of population groups. Whilst rates of infant mortality in this country are now so low that they no longer bear a systematic relationship to standards of living for large population aggregates such as regions[3] their concentration in pockets of high deprivation remains a matter for concern.

Over the course of this century there have been major shifts in the distribution of disease. Premature death is now most predominant in late middle age and caused by diseases, such as lung cancer and heart disease, more closely associated with patterns of consumption

Poverty and disease *(Continued)*

adopted as a consequence of affluence. This complete and rapid change in the cause and age location of premature death is remarkable. Perhaps even more surprising, given the increasing diversity of cultural and social experience accompanying such change, is that the reason given for premature death remains the same—it is poverty, but in different disguises.

Some explanations fall more readily than others under the umbrella of the 'poverty' principle. Certainly it is reasonable to assume that in the affluent countries of the developed world the nature of poverty itself has changed and it is relative deprivation, receiving less of the fruits of society than others, that affects the health of some population groups, rather than the absolute poverty so directly observed in infant death in the earlier part of this century. This may necessitate the development of more sensitive tools of measurement. Thus, Wilkinson[4] has used income distribution instead of gross national product per capita to measure the relative poverty of a country and has shown that for OECD countries, it is highly correlated with life expectancy: the smaller the income inequality between rich and poor groups within countries, the higher the life expectancy. It is, as yet, unclear how such differences in income distribution become translated into differences in life expectancy. Indeed, it would be interesting to see how such a measure could be used to explain existing anomalies: for example, how it is that the highest life expectancies for men in Europe today are found in countries such as Sweden and Greece, countries that fall at the upper and lower ends of the affluence poverty scale and in which one would expect to find very different patterns of income distribution.

More problematic are explanations that seek to establish the mechanisms by which relative deprivation actually causes premature death from degenerative diseases. Hence, the current debate about the social aetiology of ischaemic heart disease (IHD). Is it poverty in early childhood that causes premature death from this cause? Barker and his colleagues[5] have hypothesized that the risk of dying from IHD is determined by deprivation in fetal and early infant life, the effect being to programme biological structures that endure into adulthood. There are considerable diffculties with demonstrating that this is the case, not least the lack of information about what happens in the intervening years between childhood and middle and late middle age. There, however, is also a growing body of evidence suggesting that it is our experience as adults that is the more likely predictor of the risk of dying from IHD[6,7]. Others have plumbed the somewhat shallow depths of 'psycho-social' explanation in their search for causal links. For example Marmot, in the Whitehall studies of civil servants, found a marked social gradient in cardiovascular diseases: each employment grade had worse health than the one above it in the status hierarchy[8]. He and his colleagues have proposed that such a phenomenon could be explained by people's perception of the control they have over their own lives. People who have fewer skills and are likely to do monotonous, tedious and low paid jobs tend also to have, and to see themselves as having, little control: this means that not only are they less likely to take up preventive practices, but also lack of control in the workplace is a highly stressful experience and could contribute to earlier death from IHD[9,10]. Psychosocial explanations may well be valid to explain individual differences and, indeed, they are ripe for development in both their range and their precision. The application of psychological concepts developed to explain individual behaviour to what are in fact group differences should be treated with caution and, when applied to populations of large areas[9,4], they make little sense. Take the timing of the onset of the recent decline of mortality from IHD for men in Britain as an example. Rates of mortality from IHD have, since the 1950s, been higher in the poorer Northern regions of Britain than in the more affluent South. The onset of decline in these rates of mortality occurred at approximately the same time (1970-1975) in the North and the South and in all age groups over 357. Could this be the consequence of a simultaneous change in the psychological make up of regional populations, regardless of differences in sex, age and socio-economic circumstances? It is unlikely. Moreover IHD mortality rates have continued to fall in all British regions, despite the employment and economic circumstances of the late 1980s and early 1990s[11].

Some facts, however they are interpreted, cannot be made to fit the poverty principle and require a more flexible approach to be fully understood. First, premature death from degenerative diseases has been linked to relative affluence as well as relative poverty, suggesting that the behavioural risk factors underlying such deaths are always more characteristic of poorer populations[12,13]. Take for example premature death from lung cancer for men (55- 64) in Europe. In the 1950s rates of mortality in more affluent countries in Northern Europe, such as Austria, Finland, England and Wales, were more than double those of poorer Southern European countries such as Italy, Spain and Greece. Increasing affluence has brought a decline in mortality from IHD, which have declined in Northern Europe from the 1960s onwards, but a continuing increase in the countries of Southern Europe, so that there is now little variation in rates of premature mortality from this cause in these two contrasting geographical regions of Europe. Changing economic trends have brought with them changes in the relationship between socio-economic conditions and premature death. Or take breast cancer for women at ages 55-64. Whether comparisons are made between European countries, or between regions or social classes

(Continued)

Poverty and disease *(Continued)*

within countries such as Britain, higher rates of premature death in the post war years, have been most consistently located in more affluent socio-economic groups[14]. Such evidence sits awkwardly alongside that which shows that survival rates for women with breast cancer in this country are lower in poorer socio-economic groups[15]. Is it dietary factors that underpin such opposing trends? If so, they have a differential impact on survival and on death for women in Britain today that we need to understand.

Secondly, the relationship between our socio-economic experience and our health is likely to be age and cause specific. Conventional measures of mortality such as standardized ratios (SMRs) summarize deaths from 15-64 and, thus, can act to obscure rather than illuminate epidemiological trends. This has been well illustrated by Illsley and Le Grand's examination of age specific patterns of mortality underlying the North/South divide. Using age specific death rates Illsley and Le Grand[3] have shown that continuing economic inequality between the Northern and Southern regions of Britain from the 1950s to the present day has been accompanied by decreasing inequality at death at all ages and for both sexes, with the exception of the 45-64 age group. In fact, there is now no North/South gradient for deaths under 35. This must reflect to a large extent the effectiveness of the National Health Service in eliminating the diseases of poverty in early childhood. It is more puzzling that middle aged people appear more vulnerable to the influence of socio-economic conditions than the over 65s. A fuller interpretation of the social meaning of cause specific deaths could tell us why.

Thirdly, there are many possible social influences on our health and socio-economic circumstances, whether they be relative poverty or relative affluence, in some contexts have little to do with when we die or how. For instance, there are striking differences in rates of premature death from IHD for men and for women aged 55-64 both between and within European countries[14]. In Mediterranean countries, such as Italy and Spain rates of mortality are lower for both sexes in this age group when compared with countries such as Britain. Within all these countries women have lower rates of mortality than men, despite sharing the same standards of living. Moreover, and for no apparent reason, rates of mortality from IHD have declined at a much faster pace for southern European women over the last 40 years when compared with Southern European men and both women and men in Britain. These patterns, if indeed they are socially determined, may well reflect the different lifestyles and behaviour of men and women as determined by their culture and their status as social groups[16]. However, there is still much to be discovered from the rates and pace of change that such data reveal. Poverty explanations have to be reconciled with, and integrated into these diverse and changing patterns.

So there is a complexity about the relationship between our social lives and our health that is not simply reducible to the poverty principle. Fitting the pieces of the puzzle together means assimilating contradictory evidence at a more inclusive level of explanation. In an early and famous experiment in Gestalt psychology[17,1], a subject put on goggles fitted with inverted lenses, so that he saw the world upside down. This presented such a departure with the way that he had been trained to see that he was thrown into crisis and confusion. After a while, however, the subject learnt to deal with this new world and his entire visual field flipped over. Then he saw the same world as he had done before the goggles had been put on, but through a new Gestalt, i.e. from a different perspective. Well, why not try the goggles[7] If not for the sake of scientific inquiry, then for the sake of a broader-based approach to tackling inequality in health at the structural and the behavioural level in Britain today.

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Copic Comment

by Jerome M. Buckley, MD
Chairman & CEO
Copic Insurance Company



Copic Discounts -- Equity and Fairness

A Copic staff member recently received a letter from one of our solo practitioner policyholders. The physician felt that it was unfair of Copic to extend certain discounts exclusively to larger groups.

I explained to the physician that there are reasons why Copic cannot treat all policyholders equally, but that we are vigilant in ensuring that they are all treated equitably. The distinction is subtle but important. Equal treatment would require every discount to be available to every policyholder. Equitable treatment requires that a discount available to any qualified policyholder be available to every qualified policyholder. Within this framework, we also strive for fairness by searching for ways to reward policyholders for loyalty and favorable claims experience.

Individual physician policyholders are excluded from only three discount opportunities.

The first of these is the Administrative Group Discount, which provides for discounts of 5% to 15% for groups of five or more physicians who are billed on a single statement.The justification for the discount stems from a direct reduction in Copic's operating costs for policyholder acquisition, policy issuing, policyholder service and accounting. The second discount offered only to large physician groups is the Associated Group Risk Management Program Discount. This program is for physician groups organized under a flexible but binding structure (e.g., corporations, associations, IPAs, PPOs, etc.) which can exert greater control over medical malpractice risk and exposure through the formation and enforcement of a Copic-approved group risk management program.

The final discount offered only to physician groups is the Quota Share Deductible Program. This is a risk-sharing program for large, formally-organized, tightly-managed physician groups. The program offers premium savings to a group in return for a commitment to share in a deductible option on a 50/50 basis with Copic. Deductible options range from $25,000 to $100,000. The group must also implement an enhanced risk management program which meets with Copic approval.

With the exception of the three discounts described above, individual policyholders are eligible for up to five separate discounts and premium credits:

- Physicians who participate in the Experience Rating System (ERS) and earn points can maintain a 10% premium discount.
- Members of the Colorado Medical Society receive a 10% premium discount.
- Physicians who choose to limit their practices (e.g., part-time, office practice only, etc.) are eligible for corresponding discounts.
- Solo practitioners or small physician groups may choose to gain premium discounts through the Individual Deductible Program. Deductibles are available in increments of $5,000, beginning with $5,000 and continuing up to $25,000. A deductible option of $50,000 is also available. Corresponding premium discounts range from 6% to 20% (on policies with limits of $1 million/$3 million).
- Finally, with two exceptions, every Copic policyholder is eligible to participate in the distributions that Copic pays when favorable loss experience permits. (The exceptions are our retired physicians who receive free coverage for the pro bono work they perform and groups who have negotiated agreements which exclude them from participation.) While not guaranteed, Copic has paid such distributions each year since 1990 -- returning a total of $46 million to date on business written since 1985. This year's $6.0 million distribution represents a 15% credit on policyholders' 1997 premiums.

Copic will continue to examine ways to expand the discount structure within our framework of equity and fairness. Please contact your Underwriter if you have questions regarding the discounts for which you may be eligible as a Copic policyholder.

Are your insurance claims "lost?" Is payment delayed? We want to hear from you

by Marilyn Rissmiller, Program Manager
Division of Health Care Finance

In the January issue of Colorado Medicine we asked for your assistance in identifying insurance claim processing and payment delays. To date, we have not had an ovewhelming response, considering what is perceived to be the magnitude of these problems. This leads us to believe that possibly we missed the "key contact," in this case the billing staff...so, **will you please share this article with your billing staff**. If you are encountering any of these problems, encourage your staff to send us the necessary information.

Members continue to express their concerns over an increase in the number of insurance companies delaying claims payment, as well as, an increase in the length of those delays. The reported delays also include "lost" claims and requests for additional information (when that information was provided initially). In researching these general complaints, CMS staff has been in communication with the Colorado Division of Insurance. We have discovered two things:
(1) The existing state rules and regulations pertaining to health insurance do include a requirement (and penalty) for "timeliness of payment" (CRS 10-3-1104, section (1)(h) and regulation 4-2-7).
(2) The Insurance Commissioner's office would be willing to assist us in our attempts to alleviate these problems, if we can demonstrate a "pattern of business practice."

In order to take advantage of these discoveries, we need specific information on individual claims. This claim specific information can then be compiled to determine [and demonstrate] if there are any overall patterns. Included on the accompanying page is a tear-out sheet entitled ***CMS Insurance Problem Log.*** This log is set up to easily identify the specifics required. We ask that **a separate page be completed for each insurance company**; however, multiple patients/claims can be included per page. Please feel free to make as many copies as needed.

Our goal in collecting this data is to improve the overall timeliness of claims payments.

If you or your billing staff have any questions, please feel free to contact Edie Register or Marilyn Rissmiller at (303) 779-5455 or 1-800-654-5653.

Don't let them Suffer In Silence!

Domestic violence and child abuse are, together, one of the most frightening aspects of today's health care needs, and physicians can help in a great number of ways to curb violence and encourage reporting of incidents.

There are many things you, the physician, can do to help people in distress and whose lives are actually endangered. We have posters, physcian guidelines and resource cards available for use in your office. Carry the calendar (included in this magazine) to remind you and your associates of what else needs to be done to save lives. Don't hesitate a minute longer. Call us today! For resource materials and patient information, contact Ellen Stein in the CMS offices at 779-5455 or 1-800-654-5653, or e-mail her at *Ellen_Stein@cms.org*.

CMS Insurance Problem Log

Physician Name: _____ For: _____
(Name of Company)

Office Contact: _____

Phone Number: _____ If the insurance is contracted through a PPO, give name: _____

Patient Name	**Insurance ID Number**	Date of Service	**Charge**	**Type of Problem (check one)**			**Chronological history of claim filing and follow-up by your office** (Include dates, names of people contacted, attach pertinent correspondence.).
				Payment Delay	Lost Claim	Delay Tactics	

One (1) insurance company per page

The Health Care Financing Department will be compiling this informationin an effort to resolve issues with the insurance companies. If you have any questions you can call Edie Register or Marilyn Rissmiller at CMS. (303) 779-5455 or 1-800-654-5653.
Return completed forms to Colorado Medical Society, P.O. Box 17550, Denver, CO 80217-0550, attn. Marilyn Rissmiller.

Call for Nominations
1997 Physician Award for Community Service

The Physician Award for Community Service, sponsored by Wyeth-Ayerst Laboratories, is designed to provide recognition to men and women who are actively engaged in the practice of medicine but who, for whatever reasons, give services above and beyond the call of medical duty.

The award was established in 1961 in appreciation for the time and personal sacrifice devoted by physicians to the welfare of their communities.

The Colorado Medical Society is now taking nominations for this award to be presented at the annual meeting in September. Nominees must meet the following criteria:

1) The nominee must be a licensed Colorado physician;
2) The nominee must be living; no posthumous awards are permitted;
3) The nominee must not have received this award previously;
4) The nominee must have compiled an outstanding record of community service.

Please help to promote the image of the medical profession in its ongoing efforts to be a positive participant in community life. Nominate a colleague today! Nominations are due on or before June 30, 1997. Please call 779-5455 Ext. 2425 or 1-800-654-5643 for more details.

Call for Nominations
Colorado Medical Society Certificate of Service

Each year, Colorado Medical Society awards a physician with the prestigious Colorado Medical Society Certificate of Service, recognizing outstanding effort and devotion to the purposes of organized medicine. The award is given to an individual who displayed unusual efforts on behalf of the Colorado Medical Society, or noteworthy contributions to the practice of medicine in Colorado.

This award, given by the Colorado Medical Society Houseof Delegates at each year's Annual Meeting, goes to a physician named by his/her peers. You are urged to consider this award and the activities at both state and local levels, and nominate that individual whom you feel has made an outstanding contribution.

Nominations are due on or before June 30, 1997. Please call CMS at 1-800-654-5653 or (303) 779-5455, extension 0425, to request a nomination form.



by John L. Lightburn, MD
Historian
Colorado Medical Society

The Denver Medical Library

Author's Note: *Mary DeMund, librarian for the Denver Medical Library, has been an invaluable source of information for the monthly articles in this space, and the library she manages has an interesting history of its own.*

"...2000 volumes from the Boston Medical Library (if Colorado could pay the not insignificant freight from Boston ...)"



Shortly after the organization of both the Denver and Colorado Medical Societies in 1871, there was an effort to establish a library. As a first step, a few public spirited physicians collected some books and journals. At an 1875 meeting of the Colorado Medical Society, they brought the matter before the society with a motion to buy a book case for the books. The fiscally conservative majority, however, would have none of such frivolity and defeated the motion. The collected books were lost.

The idea languished until Henry A. Sewall started promoting the idea of a medical library. A distinguished physiologist and medical educator from the University of Michigan, Sewall had come to Denver seeking a cure for his lung disease. He recruited a number of like-minded colleagues, and on May 27, 1893, a small group of physicians met in the office of Dr. J. T. Eskridge. The group included Doctors Eskridge, H. C. Snitcher, E. J. A. Rogers, W. P. Munn, J. N. Hall, W. A. Nicherson, Henry Sewall and, by invitation, J. C. Dana, librarian or the Denver Public Library, then located in the East Denver High School at 19th and Stout streets. They elected Dr. Eskridge as president, Dr. Sewall as Secretary/Treasurer and appointed a committee to write articles of incorporation for the Colorado Medical Library Association. Physicians of the state were invited to join the association with annual dues of $5.00. With the permission of Mayor Platt Rogers, Librarian Dana offered space in the public library for a medical section and agreed to match the contributions of the physicians. Colorado Medical Society gave $200.00 and the Denver Medico-legal Society gave $75. With a new constitution and bylaws, they were in businsss with over sixty members of the association. Publicity about this new library brought contributions of books from many sources: 2000 volumes from the Boston Medical Library (if Colorado could pay the not insignificant freight from Boston to Denver), numerous volumes from the New York Academy of Medicine, the King County Medical Society and from the Surgeon General of the Army (books from abandoned army posts).

After discarding duplicate and obsolete volumes, the secretary's report at the end of the first year listed 1,176 volumes. Not a bad

(Continued)

start, but in spite of enthusiastic support from Drs. Sewall, Eskridge, Sam Fisk, C. D. Spivak, T. H. Hawkins and others, interest waned, dues payments declined and the association's financial condition became increasingly desperate. Librarian Dana left for greener pastures and the Public Library was evicted from the East High School building, moving into cramped and unattractive quarters. By 1900, this was remedied by Andrew Carnegie's gift to the city of a large, state of the art, library building that still stands at the corner of Colfax and Bannock Streets. Although the new building provided attractive and roomy quarters for the medical section, the fortunes of the Medical Library Association continued to decline. The Denver Medical Society seemed unwilling or unable to help. Finally in 1907, with the encouragement of Drs. Sewall and Walter A. Jayne, the resources of the library were transferred to the new Denver Academy of Medicine, which showed some promise of financial stability and permanence. The Academy had rented space at 1454 Glenarm Street for a meeting room and a library for $40.00 per month. Again the future of the library looked bright, and Drs. Sewall and Jayne felt reassured.

But there were grumblings. Even in the good old days doctors grumbled. The Fellows of the Academy much preferred to present their scientific papers to the Academy where there was a larger and more receptive audience. This diminished attendance at the county Medical Society's meetings and caused some antagonism toward the elitists in the Academy. Cooler heads agreed that the community could not support two major medical organizations and that amalgamation of the two should be considered. The academy agreed to the merger only if the society agreed to support the library.

Negotiations followed and committees of both the Academy and the Society reached an agreement that the Society could take over the assets of the Academy if it demonstrated for three years its ability to support and maintain the library.

Was this Henry Sewall's strategy, to form a rival organization to finally convince the Society to adequately support the library? That library would eventually even have its own building.

Presidents of the Academy during its brief life were:
1904, Henry Sewall;
1905, George B.Packard;
1906-1907, Walter A. Jayne;
1908-1909, William W. Grant.



Dr. Henry Sewall

So the Denver Medical Society had its very own library, a responsibility it had been avoiding for 36 years. But the trustees and officers had a plan. The Metropolitan Realty Company was building a beautiful, new six story office building exclusively for physicians and dentists at the corner of 16th Street and Court Place, across the street from the Arapahoe County Court House. With skill and eloquence, they persuaded the realty company to rent to the Society enough space to accommodate a meeting room, reading room and stacks all for the princely sum of one dollar per year!

For the next twenty-two years the library thrived with a steady growth of clients, contributors and benefactors. In 1910, there were slightly more than 6,000 volumes on the shelves. In 1912, a permanent endowment fund was established with the $1000 left by T. J. Eskridge. The trustees of the Denver and Gross Medical College, having merged with the University of Colorado, gave $9,793 to the endowment fund.

With this growth and use, more space was needed and the Metropolitan Building obliged. The continued growth was due in large



The Steele Block at 16th and Stout Streets9n Denver, built in 1882, figures in the annals of the medical schools of both the University of Denver and the University of e residence of Dr. Henry K. Steele, first dean of the University of Denver Medical Department, who conducted some of his classes in his home. (Western History Section, Denver Public Library)

part to the dedication and enthusiastic support of physicians like Walter A. Jayne, Henry Sewall, James J. Waring and Nolie Mumey. In 1928, Dr. Jayne died and the library lost a good friend. But he left a bequest of $2000 to the library building fund, a tangible expression of his dream.

In addition to support from the Denver Medical Society, a number of physicians gave directly to the library, either in the form of money, books or subscriptions to specialty journals. This helped the library survive in the great depression of the 30s. Rare books and museum pieces were received and a small medical museum was started. Then, in 1932, Dr. Jim Waring learned that his friend, Dr. H. M. Evans, the California physiologist who had discovered Vitamin E, was planning to sell his collection of rare medical books. Waring persuaded him to sell the

collection to the Denver Medical Library for $6,000. This sum was paid off by Waring, his brother-in-law, Henry Porter and other friends without any assessment to the membership. This was no ordinary collection. Among the thousand or so books were two folio volumes of beautiful anatomical drawings on heavy velum: one was a 400 year old first edition of ***Anatomy*** by Andreas Vedalius; the other was a second edition. There were 180 other rare classics from the 17th and 18th centuries, including works by Eustachius, Fallopius, Harvey, Koch, Virchow, Hunter and Laennec. There was room to display only a few of these so the major portion of the collection was put away in vaults and storage boxes.

By 1951, the library had 37,890 volumes and an endowment fund of $190,997. The need for more space was urgent. To add to the crisis, the Metropolitan Building indicated their intention not to renew the lease. A new building was no longer just an option. Nolie Mumey, chairman of the building committee, sprang into action, obtained a favorable ruling from the Internal Revenue Service concerning tax deductibility of contributions and spent many hours campaigning for funds. Negotiating a long term lease from Presbyterian Hospital, the building committee started construction of the new library building and DMS offices. The building fund did not cover all of the expenses so the trustees assessed each member of the society $300. The response to this was mixed; some soreheads resigned; some truly could not afford the burden and new physicians decided not to join. Dr. Jayne's and Mumey's dream had become a fiscal nightmare, and the trustees struggled to find a solution, moving the library to the basement and leasing the main floor. But expenses rose and the debt persisted. Looking everywhere for help, they discovered a hidden treasure from the past, the Evans collection of rare medical books!

The trustees were divided. How could they sell such a treasure and betray Dr. Evans' trust? On the other hand where could they get the $9,000 annually to safely store and display the collection? After months of discussion and negotiating, the books were shipped to New York for auction in 1975. Dr. Henry Toll accompanied the books to the auction. Sitting in the front row at the auction, he bid on any book that was going too cheaply, and returned to Denver with a heavy suitcase of books, including the second edition of the Vesalius folio. The auction netted almost $250,000 which solved the financial crisis. The trustees eventually gave the Vesalius and a few others to the University of Colorado Health Sciences Center.

The library survived until 1989 when Presbyterian Hospital was sold to a national chain of hospitals, and the decision was made to level Grasshopper Hill and build a new medical center in which the library would be provided with space and a $1.00 per year lease.

And there the library is today with Mary DeMund and her friendly, helpful staff serving the clinicians of the community with prompt and efficient service. Supporting the library is an endowment of over $300,000 and Friends of the Library numbering about 125 with the following as members of the board: Jack Chang, M.D., Chairman; H. Blair Carlson, M.D.; David Classen, M.D.; Kathy Lindquist-Kleissler, DMS; R. Lee Jennings, M.D.; Bob Parsons, M.D.; Janet Schemmel, M.D.; Richard Talbott, M.D. and Giles Toll, M.D.

The Internet and the world wide web may change our library beyond recognition, but hopefully, a little of the old magic will remain.

As Dr. Tom Coleman once wrote: "Some January afternoon, I may want to stroll past the green-eyed computer screen to sit there and ask a friendly human librarian to let me read the original papers that William Osler sent us. Music would be nice, and coffee later".

The Denver Medical Library Today and Tomorrow

by Bill Pierson, Editor
Colorado Medicine

CMS Historian John Lightburn, MD, has certainly given us a lively and colorful account of the Denver Medical Library history, but in addition to providing excellent reading it gives us pause for thought about: "What will the Library be tomorrow?

Currently, the Denver Medical Library Foundation has an agreement with Columbia Presbetyrian/St. Lukes to operate the Library in its present location until the year 2112. The Library has a healthy but limited funding from present endowments, trusts and funds from friends of the Library. These are very short-term assets which must be continually renewed or the Library will not be able to operate until 2012, much less beyond.

The Foundation Board, chaired by Dr. Jack Chang, is currently working on a draft plan whereby these assets can be substantiated into the future. The plan includes re-directing the Library in its scope of service, and the expanded purpose and marketing of these facilities.

Ned High of *Ned High Public Relations* and Al Haggerty, long-term planning consultant to health care entities, both have volunteered to help develop plans along these lines. Colorado Medical Society and Denver Medical Society have both agreed to help in the development of the long-range plans and to disseminate information in support of the new Library goals.

This is an exciting time for the Denver Medical Library, faced with the many developments in electronic communication and data storage and retrieval. However, we must not allow the Library to dissolve into the etherial realm of *"bits and bytes"*.

We must protect it in its present mode of *"books and balm."*

HIGHLIGHTS OF BOARD OF DIRECTORS MEETING - January 24, 1997

Copic: Dr. Jerome Buckley, CEO, Copic, thanked the Colorado Medical Society (CMS) for alerting them to the article written by the Board of Medical Examiner's (BME) attorney, Matthew Norwood, interpreting the Medical Practice Act. Gadrian is going to have an educational credentialing program with El Paso County Medical Society, Mesa County Medical Society and Denver Medical Society. Copic's Annual Meeting is scheduled to be held on February 26, 27, and 28. Copic has had a successful year; they are at an all time high for number of insureds.

CMSA: Ms. Stella Shanks reported that the Alliance's next event will be "Day at the Capitol", on March 3, 1997. The Alliance has arranged a Continental Breakfast from 8:00 am - 10:00 am in the old Supreme Court Chambers. A workshop will be held from 10:00 am-12:00 noon. Mr. Jerry Johnson will be one of the speakers at this workshop. Ms. Shanks invited the Board members to attend. The Alliance Annual Meeting will be April 24-25, 1997, in Vail, Colorado. Long Range Planning for the Alliance will be the main focus of the meeting.

AMA Delegation: Dr. Quinn presented a brief update on the 1996 AMA Interim Meeting. He stated that Dr. Joel Karlin was successful in the passage of the resolution regarding individually owned and selected health insurance, and was given special mention at the AMA House of Delegates by Dr. Stormy Johnson. AMAP continues to move forward. The AMA continues with their policy that HIV testing be mandatory for pregnant women. The AMA also continues to be adamantly opposed to physician assisted suicide. Dr. Dick Allen is up for reelection to the Council on Medical Education this coming June.

Medical Executive Group: Ms. Judy Ladd reported on the Medical Executive Group meeting, held on 01/24/97 at 10:00 am. Chet Seward presented the CMS Internet Web Page, and Merrill Lynch presented their physician's financial program. The new chair for the medical executives will be Brad Darley. Ms. Ladd stated that she had mistakenly announced that Carol Walker was going to serve on the governing board of AMAP.

Finance Committee: Ms. Maloney explained the audit report. She thanked the Finance Committee and Ms. Nan Deter for their excellent job. CMS had a very good year.

CROP: Mr. Peter Milstein presented an update on the Colorado Rural Outreach Program (CROP), and explained that in order for CROP to continue, further money would be needed. The Finance Committee and the Board of Directors approved a loan to CROP.

Council on Legislation: Dr. Painter then discussed disclosure. He explained that CMS is attempting to get the health insurance companies to formulate uniform disclosure in health plans. The Department of Insurance does not have authority to mandate uniform disclosure through Rules and Regulations, so legislation providing needed authority will be sought. Dr. Karlin briefly stated that meetings have been held on Monday mornings to discuss disclosure. He thanked Ms. Edie Register for her assistance with these early morning meetings.

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David C. Martz, MD
President
Colorado Physician Network

National focus on Rocky Mountain Physicians' Choice

Colorado Physicians Network and Rocky Mountain HMO have moved into the national spotlight following failure of the Florida Medical Association's HMO effort! Attempting to raise $20 million by physician investments of $500-50,000 each, Floridians called it quits when only 350 members anted up a mere $2.4 million. The California Medical Association has raised its $6 million target from 7,450 physician owners--yielding almost 1.5 doctors for each of its 5,000 enrollees. The Kansas Medical Society has created Heartland Health which has recruited 2,100 physicians and 8,000 enrollees entirely from rural communities; Kansas City comes later. According to an article in the February 3 A M News, only 7 state medical societies are pursuing a physician-driven HMO, and only 7 others are considering other managed care alternative options.

That puts us exactly where we want to be: out in front, making tracks where only a few have ventured. Our approach is unique--a joint collaboration with an existing HMO having over 20 years experience, almost 100,000 covered lives, and mutually compatible core values.

In the past month we have been concentrating on enhancing our PCP panels, clarifying our marketing strategy, and developing additional aspects of differentiation from other managed care programs. For example, we are pleased to report that the Rocky Mountain Physicians' Choice program will include the option of very low cost dental insurance through the auspices of the Alpha Dental HMO panel. The price of this combined package will be extremely competitive with other products on the market. We have added several major PCP groups in the Denver-Metro and northern Front Range communities. We are exploring the feasibility of a niche market in college student health programs. Most importantly, we are enrolling employers in the Phase I territories, so you will have patients to treat! Although several major impediments remain ahead of us at this time, we are making very satisfactory progress on all fronts. We have every reason to believe that we are avoiding pitfalls others have taken, and that we will continue to model (for the entire nation) a successful physician driven health care program in Rocky Mountain Physicians' Choice: **You Never Had It So Well!**

Don't let them Suffer In Silence!

For resource materials and patient information, contact: Ellen Stein at the CMS offices at 779-5455 or 1-800-654-5653 or E-mail *Ellen_Stein@cms.org*.
There are so many things you, the physician, can do to help people in distress and whose lives are actually endangered. Carry the calendar (included in this issue) to remind you and your associates of what needs to be done to save lives.
Don't hesitate a minute longer. Call us today!

Standing room only:
Medical indigence in Colorado

by Chet P. Seward, CMS Communications



Last year the InnerCity Clinic in Denver provided care to 14,000 patients who were medically indigent.

Unemployment is probably the last thing most practicing physicians desire, but that is exactly what Ed Farrel, MD, wants. He is not like most physicians. Along with a number of other dedicated health care professionals, Dr. Farrel provides free medical care for Denver's indigent population at the Stout Street Clinic. "I'd love to be unemployed," says the clinic's medical director, "because that would mean that there are no homeless in need of care". His full-bearded, boyish grin quickly turns solemn when he adds, "that's not going to happen".

Medical indigence is a bi-product of America's economy. Booms and busts succeed in swelling the ranks of those who cannot afford medical care. Homelessness, physical and or mental illness, unemployment, or lack of employment which provides benefits all play a role in the complex equation that is medical indigence. There are no easy answers. Arguably there are only more questions to this systemic problem which will always be present.

Access to care

For a person whose major priorities for the day are securing food and a dry, warm place to stay, finding quality medical care is important only when an emergency arises. Yet that is why access to quality care is so critical. Clinics like InnerCity at 3405 Downing, headed by Dr. Robert Williams, or the one on Stout Street are the primary sources for care for thousands in the Denver-metro area.

Part of the Colorado Coalition for the Homeless, the Stout Street Clinic provides health maintenance, preventive, acute, chronic, prenatal, postnatal, gynecological and respite care for Denver's homeless population. Crisis management and outreach programs serve the mentally and emotionally ill, along with those who are substance abusive and dependent. An on-site pharmacy and dental facility also provide services.

The InnerCity Clinic utilizes a sliding fee schedule to provide care for the indigent. Patients pay what they can. Similar to Stout Street, InnerCity uses educational programs on subjects ranging from diabetes to the effects of smoking during pregnancy to help provide the best possible care to those in need. It is through services like these that both clinics strive to provide and maintain their commitment to those who are unable to access the same caliber of care found in private practice.

The rising tide

A majority of those who are medically indigent come from poverty level backgrounds. However, medical indigence occurs at all levels of society. Over the 13 years that he has been providing indigent care, Dr. Williams notes that the socioeconomic factors are generally the same, but the demographics are still changing. In the past his patient base used to be one-third black, one-third Hispanic and one-third white. Now, about 50 percent of his patients are Hispanic and 25 percent of those are Spanish speaking only. The demographics will inevitably continue to change.

Homelessness may be the largest contributing factor to medical indigence. Almost 75 percent of the homeless are men, and many of them utilize indigent care. However, the stereotype ends there because 75 to 80 per-

cent of the medically indigent are single parent families, and 15 to 20 percent of those currently being served are children. Last year the Stout Street clinic had almost 34,000 patient encounters. With an annual budget of $1.35 million, the clinic is constantly struggling to use the scarce resources provided by equal funding from Medicaid, federal grants and private/corporate donations. The on-site pharmacy has a part-time paid pharmacist and the services of a full time technician donated by a local hospital. On average, they fill 180 prescriptions a day. Over 5,000 patients consider the InnerCity clinic to be their primary source for care. Last year InnerCity provided care to over 14,000 people on a budget that is 70 percent funded by patient fees and 30 percent funded by donations.



Dr. Farrel relies on the "little victories".

In Dr. Farrel's words, "It's not just a matter of these people getting their acts together". For any number of reasons, either self inflicted or other, these people do not have the economic resources to access private pay care. The problem is that the medically indigent population keeps on growing, while access to care continues to dwindle. "We're totally saturated," says Dr. Farrel. "There is really no way that we can handle any more cases".

A commitment to care

More clogged emergency rooms, overuse of emergency services, deteriorated public health, and even social decline mark the alternatives to not providing indigent care. Why do physicians like Ed Farrel and Robert Williams do what they do? Is it because they believe in social justice? Does their motivation come from religious convictions? Or are they driven by the basic principles of medicine? Perhaps the best way to classify indigent care providers is to describe them as having an internal commitment.

Dr. Williams concedes that providing indigent care is not for everyone. Along with partner Duane Claasen, MD, he splits his time between running a private family practice in Lakewood and the InnerCity Clinic in Denver. He notes that typically doctors with successful private practices volunteer because they want to give back to the community. Some physicians believe that they are "giving" to the community by providing care. Dr. Williams disagrees, "that's not giving, that's business". "What we're doing is more, we're giving the same service at InnerCity that we give in our private practice". He thinks that every physician should volunteer more time.

Dr. Farrel works full-time at the Stout Street clinic. His pay is much lower than the salaries of colleagues in private practice. He sees more abuse, neglect and violence than most physicians. Some may find his working conditions disagreeable. Yet through it all he professes "I love what I do. You have to take joy in the little victories".

Filling in the cracks

The ranks of the medically indigent will inevitably grow once the current attempts at welfare reform take effect. Many people will not be able to make the transition, and the demand for indigent care will increase.

These effects may make it impossible for some to break the cycle. They move from Medicaid to self-pay to indigence in an unending loop of underserved care. Currently there are two patient populations at InnerCity – those that are in the neighborhood who rely on Medicaid and Medicare, and those from around the metro area who depend on the sliding fee schedule or complimentary care. Because many of the medically indigent reside in urban areas, any attempt to provide more access via the suburbs will create other conflicts. The reverse is true for rural areas, because finding access anywhere is a problem. Social mores, prejudices and other factors effectively prevent integration. For better or for worse, medical indigence is a systemic problem.

Some see a potential solution in the belief that access to health care is a basic right which should be mandated by the government. Others take a more conservative approach by advocating for a system in which employers are required to provide health benefits, and the market is allowed to equalize any disparities. Policies to address these issues must be created, and physicians must play a role in that process.

Many of the hospital systems, community clinics and other programs in the state provide care to the indigent. However, the system-wide fiscal crunch has reduced funding. Moreover, the medically indigent frequently fall through the cracks of the current health care system. All these factors augment the need for clinics like Stout Street and InnerCity. Many physicians regularly volunteer their services, and many residency programs partner with clinics to provide training and care. However, more physician talent and time is needed.

Perhaps the best way to solve the problem of medical indigence is to follow the lead of physicians like Robert Williams and Ed Farrel. Whatever the motivation, Dr. Farrel concludes, "All of us should try to reach out to those in our midst that we would like to forget".



The lines are long and the demand for care is always high at Stout St. Clinic.

Leaving the bedside? – Yes or no?



by Leigh Truitt, MD

Decreasing reimbursement, increasing administrative hassles, and other unfulfilled expectations – medicine is not always what we thought it would be. Is clinical practice still our best career option?

Since I left clinical practice, the most common questions I hear from my colleagues are why did I do it, how did I do it, and what has been the end result? Although there are several publications that attempt to answer these questions, most of you would like to hear first hand experiences from physicians who have moved from the bedside to administrative medicine or the life of an entrepreneur.

Being a physician is no longer a "no brainer" when it comes to financial and professional success once you have hurdled the obstacles of medical school and residency training. Although patient care remains a deeply satisfying experience, many of us would like to explore other possibilities that can stimulate us and build on the knowledge we have acquired in clinical practice. Our choices may be to retire, retrain, relocate, retrench, or to move outside clinical medicine.

What we don't have is enough hard information to understand both the options available and the implications of these options. Physicians may have a vague sense of dissatisfaction with their current situation but not understand the time and training requirements to move on to a different role in health care. Frequently I have found that gaining a little knowledge about what is out there is enough to make a physician appreciate more what he or she is currently doing.

Terry Sullivan, MD, Elizabeth Kraft, MD, and I have therefore decided to attempt to answer these questions by organizing a seminar, "Leaving the Bedside – Yes or No?" On June 6, 1997, in the auditorium of the General Classroom Building at the University of Denver, we will present a six-hour discussion covering:

- What is the future of clinical practice?
- What are the potential job opportunities outside of clinical medicine, including becoming an entrepreneur?
- What are the educational and training options – from week-long training programs to full graduate degrees?
- What is the step by step process in finding a new job?

Mary Frances Lyons, MD, a well-known executive search consultant with Witt/Kiefer, will lead you through the job search, resume, interview, and contract negotiation process. You may be familiar with the series of articles on these topics that she has written for *The Physician Executive*, the publication of the American College of Physician Executives.

Included in the price of the seminar are the AMA publication, *Leaving the Bedside*, and a short form of the Meyers-Briggs personal

(Continued next page)

Being a physician is no longer a "no brainer".

Leaving the bedside cont.

ity inventory test. Jean Cooper Carey will provide an overview of this test and how varying personality types fit into differing occupational roles.

We will also feature a panel of physicians from Colorado who have made the transition from clinical to administrative medicine or entrepreneurship. They will tell you their motivations to alter their career paths, how they went about this change, what have been the end results both financially and professionally, and then answer your questions.

The price of the seminar is $150. COPIC Insurance Company, with the additional support of the Colorado Medical Society, will sponsor the seminar. Look for additional details in the mail soon. If you would like more information now, please call Elizabeth Kraft at (303) 333-0900, extension 224.

Our expectation is that you will leave the day with:

- a better understanding of what faces you in the practice of medicine in the future;
- a list of non-clinical professional opportunities that are available to you;
- knowledge of how you can train for those opportunities; and
- guidelines as to how you can actually go about searching and applying for your desired position.

Most important of all, we hope you will understand that clinical and non-clinical roles differ in both their professional demands and rewards. On the one hand, you may leave with the information necessary to change your life. However, on the other, you may decide that life at the bedside is the life for you!

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Advances in Medical Informatics

Liability Aspects of Drug Interaction Software

Part 1: The Need

by Michael S. Victoroff M.D.



"... explain to a patient who is harmed, why it was just too tedious; or expensive; or boring; to bother..."

Dr. Victoroff chairs the CMS Committee on Medical Informatics. He can be reached at informatics@cms.org.

One of the most valuable applications of computers in ambulatory practice is for the evaluation of drug interactions. Because of the combinatorial problem created by multiple prescriptions, this task is essentially impossible to do manually. Computers reveal their greatest utility where manual calculations are infeasible.

For the following reasons, we are about to see a standard of practice emerge around the use of automated drug interaction checking (ADIC) systems:

- The domain of knowledge about drug interactions is well defined. A reasonably comprehensive database occupies a few megabytes. Inexpensive and effective software for ADIC is available from several vendors.
- Prescription management is complex in today's medical environment. In cost benefit terms, the harm done by ignorance of drug interactions - and the liability - is substantial, while the cost of reducing adverse drug events is modest. This gives us a highly "leveraged" ratio of risk to expense.
- The availability, low cost, ease of use, and clinical value of ADIC software makes it an essential tool. In 1997, the hazards of not having ADIC in our offices (and using it!) outweigh virtua!ly all objections. The attentions of patients, quality monitoring organizations and malpractice insurers are increasingly turning toward this arena.

This article will extol the value of ADIC software, and argue for its broad and immediate adoption. Next month's article will point out the shortcomings and hazards of this essential tool.

Can't Be Delegated

ADIC can't be left to pharmacies. Although many have ADIC capability, it is exceptional for a pharmacy to have a complete list of a patient's medications. Whereas, knowing all active medications is a rudimentary responsibility for any physician prescribing a drug. Nor can pharmacies accept the responsibility for overriding warnings to patients, when therapy requires accepting special risks.

And, since clinicians are responsible for the informed consent involving their own prescriptions, we can't depend on our colleagues to do our checking for us, or to make our judgements about which interactions to accept.

"Flat File" Databases

Many sources publish drug data for clinicians and patients in "flat" or "document oriented" formats, both printed and electronic. These are merely collections of articles, and not true ADIC programs, since they can't perform the combinatorial searches of a relational database. While some of these have virtue, they do not replace the need for ADIC.

The P.D.R. is particularly inadequate, in both formats. It is limited to manufacturers' package insert information, which varies widely in reporting interactions, and is often incomplete .

Scope of Reporting

ADIC should monitor *drug/drug, drug/disease, drug/food,* and *pre-*

(Continued next page)

(Drug interaction continued)

scription/OTC conflicts. Interactions should be checked on an "ingredient" level, since adverse reactions may occur due to "inert" dyes, binders, emulsifiers, etc., as well as to "active" components. ADIC should flag therapeutic duplications (such as multiple sedatives). If IV solutions are prepared, they should be checked for admixture compatibilities.

Many "interactions" are clinically trivial, or only theoretical. Others may be beneficial; or merely neutral synergisms or antagonisms, which clinicians routinely account for in prescribing. ADIC systems should allow clinicians to "set" the level of significance where warnings appear.

Drug Dose Calculation

Some programs perform *dose calculations*, based on body weight or surface area, or even sophisticated algorithms using factors such as BUN or creatinine clearance.

Dose calculation is a separate problem from interaction checking. It is much more complex and prone to error. However, some evidence indicates that dosing errors cause at least as much morbidity as interaction errors. The programming sophistication required for dose calculation is at least an order of magnitude more complex than for interaction checking.

Ideally, our computers would know if patients are genetic "slow metabolizers," the status of their tissue cytochrome systems, the condition of their gut, and the time and composition of their last meal, before advising on dosing. But, even without complete clinical information, there are still benefits in warning when prescribed doses exceed rational ranges (for example, in pediatrics), or neglect obvious factors (like anuria).

Practical Issues

Freestanding ADIC software now sells in the range of $250-500 for a single user. Networked versions are available. The knowledge base is usually maintained through annual, quarterly, or monthly updates. This cost is normally included in the software license. Some "office management" software contains integrated ADIC (with wide variations in quality).

"Payback" on the initial ADIC investment obviously depends on how often it's used. Most clinicians would agree that 100% screening is unnecessary, cumbersome and costly. At the other extreme, minimal screening would require ADIC only for drugs that are notorious for interactions. Unfortunately, many drugs without a reputation for mischief still cause major problems in unusual combinations.

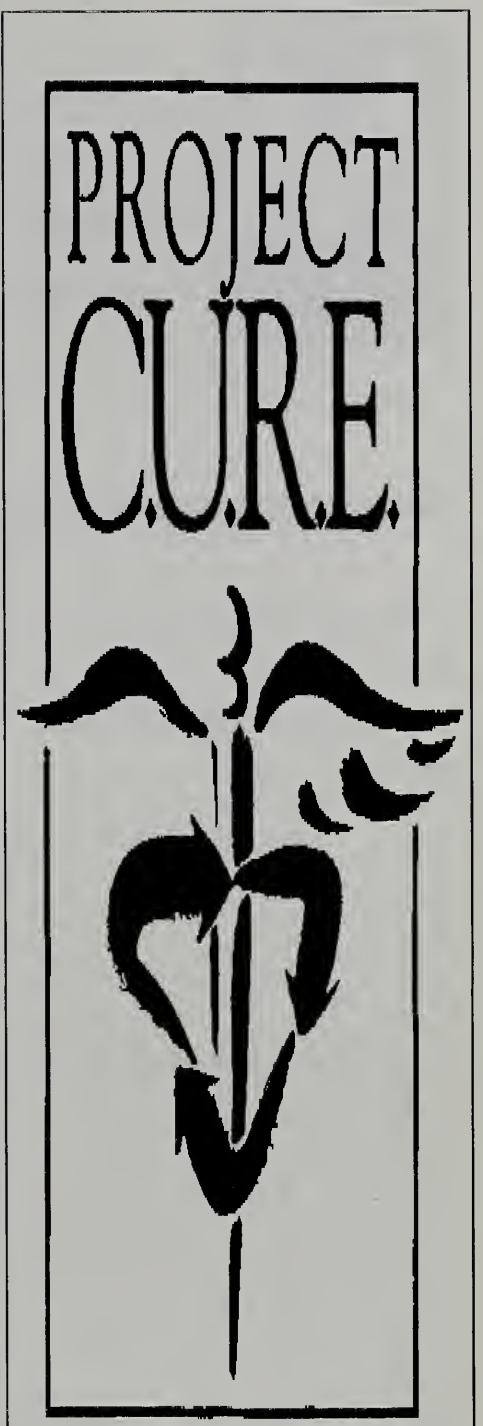
The diligence with which interactions should be checked depends on how willing we are to explain to a patient who is harmed, why it was just too tedious; or expensive; or boring; to bother performing the search which would have spared them hazard.

Since many pharmacy systems already routinely check our prescriptions, we have a public relations success when we can intercept real problems before the patient first hears of them at the pharmacy. Plus, it's good to prepare our patients for inconsequential warnings, when we know they're going to arise.

Summary

Despite vulnerabilities (to be discussed in Part 2), the potential benefits of ADIC software are too important to ignore. *The chances of harming a patient after a good faith search of a well maintained database are fractional, compared to the risks of failing to check.*

Nature makes it impossible to promise patients that any given prescription will be "safe and effective." But the current state of the art would improve considerably, if we all routinely used ADIC systems in our practices.



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Medical Savings Accounts:
Your cure for rising health care costs?

by Chet P. Seward,
CMS Communications

"Many physicians in Colorado may be in a position to benefit from MSAs."

Medical Savings Accounts (MSAs) have been in the spotlight for the past year. Legalized with the recent passage of the Kennedy-Kassebaum bill and instituted under a national pilot-study program, MSAs have been heralded as a way to cut health care costs. Critics argue that the plans cover only the wealthy, healthy and young. Described as tax subsidies for the rich, opponents hold that MSAs will "cherry pick" or siphon off the healthy patients from the current employer-based health care delivery system, thereby driving up the cost of care. Proponents argue that these medical IRAs will help simplify the system and give consumers more responsibility and choice in their health care.

Many physicians in Colorado may be in a position to benefit from MSAs. Whether you are self-employed, or if you employ a small staff, you may be able to realize big savings in health care insurance costs by using an MSA. The Copic Agency now provides two separate MSAs, which include a major medical policy from Time Insurance Company or Employers Health Insurance Company. The Time plan is for self-employed individuals. Employers offers group plans. Be sure to talk to your Certified Public Accountant (CPA) and/or your attorney to see if MSAs are right for you.

Anatomy of an MSA

MSAs are tax-favored accounts set up to pay for medical care and to allow for the build up of savings to pay for future medical expenses. The accounts take money that is currently being used to pay a health insurance premium and redistributes it. Instead of buying low-dollar deductible policies, employers buy high deductible catastrophic policies and give employees tax-free money in MSAs to spend on routine care. MSAs provide funds to pay for health insurance policy deductibles/out-of-pocket expenses or qualified medical expenses (e.g. vision, dental) *not* covered under a health plan. This gives employees the incentive, and responsibility to make choices and control their own health care costs. Earnings on savings from MSA monies not spent over the course of time accumulate tax free. Use of MSA funds for non-medical reasons is subject to income tax in addition to a 15 percent penalty. There are circumstances under which the 15 percent penalty is waived (i.e. death, disability, Medicare eligibility).

Maximum MSA contributions are 65 percent of the deductible for an individual insurance policy and 75 percent of the aggregate deductible for a family policy. These maximums have been established by law. In most cases, interest accrues on contributions to MSAs as long as you keep a minimum balance. These funds can then be used to pay for medical expenses. A certain percentage of both the contributions made to MSAs and premiums paid for the major medical policy is tax deductible. The maximum deduction in 1997 for a self-employed individual is 40 percent. The deduction increases in 1998 to 45 percent, and by the year 2006 it will be 80 percent. Deductions for groups of 50 and under are also possible. Call your CPA for details.

Cutting through the numbers

Under the two Copic Agency brokered plans, you choose the amount of coinsurance and stop loss coverage to accompany your MSA. The amount of contributions that you can make is proportional to the deductible you choose. Stop loss limit rates govern your out-of-pocket expenses according to your coinsurance rates.

Figure 1 (right) displays the three deductibles levels and corresponding maximum contribution levels for the Time Insurance and Employers plans. The Time plan offers three different coinsurance rates at 100, 80 and 50 percent. They also maintain MSA accounts. Employers offers 100 and 80 percent indemnity co-insurance, or a 90/70 PPO plan. The 90/70 PPO plan allows a small group to mix and match coverage – some with MSAs and some with the usual low deductible, non-MSA plan features. Custodial services for the Employers MSA is provided by Firstar Trust Company. Both plans require either a minimum deposit or a minimum balance in their MSAs. They also offer options for MSA contributions to be invested in mutual funds.

INDIVIDUALS		YOU AND DEPENDENT(S)	
Deductible	Deposit	Deductible	Deposit
$1,500	up to $975	$3,000	up to $2,500
$2000	up to $1,300	$4,000	up to $3,000
$2,250	up to $1,462	$4,500	up to $3,375

Figure 1

Prognosis

Determining whether MSAs are right for you should be a decision you make with your CPA and/or attorney. The plans do offer more choice and control for health care consumers. They also necessitate greater care and responsibility to "shop the market". Many people have come to expect the coverage of low deductible, low co-payment employers' paid coverage. In order for MSAs to gain mass appeal, it may take a societal reevaluation of what health insurance really should be. Until then, these medical IRAs will offer a select few increased purchasing power with tax deductible dollars, tax deferred interest, and potential savings on medical expenses.

For plan specific information, please call Dick Martley at the Copic Agency at (303) 930-0483.

YOU

THE NUMBER 1 REASON YOUR PATIENTS WILL HAVE A MAMMOGRAM THIS YEAR.

No matter what your specialty, the American Cancer Society needs you to recommend an annual mammogram for every woman over 50. An annual mammogram is critical for early detection and intervention, yet too many women are not hearing this message.
Take the first step. Call 1-800-ACS-2345 for information that can help you make an impact.

give the word.

MAMMOGRAM

EVERY YEAR AFTER 50

Ad Council A Public Service of This Publication

AMERICAN CANCER SOCIETY

HCFA Medicare Managed Care Competitive Pricing Project

HCFA has chosen the Denver metropolitan area as the first site for implementation of their Managed Care Competitive Pricing Demonstration Project. The demonstration project will last 3 years and include five Denver metro counties (Denver, Adams, Arapahoe, Douglas and Jefferson). Boulder may be included. The three main goals of the project are:

1) Determine the impact of a market based competitive biding system. All those HMO's currently in the market will have to bid to stay in the market. The "bidding" will set the government contribution level. There will be a standard package of benefits which will include statutory plus "market-based" benefits. (Any difference between the government contribution and the plan's actual bid would be the beneficiary premium.)

2) Measure the effect of an "informed" beneficiary population. Benova (an independent contractor from Oregon) will provide the beneficiary educational piece. The educational material developed will be neutral, it will not be pro or con managed care. In addition, they will provide an "800" number for beneficiaries with questions.

3) Measure the impact of a third party enrollment broker. Benova will also act as the enrollment agent for all managed care plans. The plans can still market and sell their products, however, the beneficiary will be enrolled in their chosen plan by Benova. Beneficiaries will not be locked in, they can still change monthly. There will be an open enrollment campaign each fall.

Timeframes are:

- February through March 1997 – Start bid process
- May 1997 - Set government contribution level
- Summer 1997 - Begin education & beneficiary seminars
- Fall - Open enrollment
- January 1998 - New plans effective

HCFA officials will be meeting with local HMO representatives later this month to provide more information on the bidding process. One of the obvious results HCFA expects to achieve is a lower per beneficiary reimbursement rate to the plans.

It is probably too early to determine what the impact will be on the physicians who currently participate with the local Medicare HMO's. However, it would be a good idea for physicians to look at their contracts, and be prepared to ask the individual HMOs questions as this project moves forward.

For more information please call Marilyn Rissmiller in the CMS Health Care Financing Department at (303) 779-5455 or 1-800-654-5653.

AMAFPS develops new services to aid physicians and group practices

The American Medical Association's subsidiary, AMA Financing and Practices Services (AMAFPS) has changed its name to AMA Solutions, Inc. to reflect the expanded services provided under their new services – AMA PracticeLink and AMA PersonalLink.

AMA PracticeLink provides a unique portfolio of products and services like telephone service, credit card acceptance programs, and supplies purchasing programs to group practices.

AMA PersonalLink focuses on the individual needs of physicians by providing services like home equity and mortgages, automobile leasing, and a full line of insurance products.

Both "links" supply physicians with comprehensive and innovative solutions to personal and practice needs.

MGMA addresses benefits and dangers of new communication technology

The Winter 1997 issue of *Personnel Postscript*, published quarterly by the Medical Group Management Association (MGMA), discusses some of the ramifications of new communications technology on medical practices. Recommendations for medical practices are made regarding the use of electronic mail, voice mail, telecommuting, electronic data storage, and facsimiles. Pertinent laws, both federal and state, which have been enacted in an attempt to address these concerns are also highlighted.

For more information please contact MGMA at (303) 799-1111.

Colorado program selected to coordinate universal newborn hearing screening

The U.S. Public Health Service has awarded a four-year, $1.3 million grant to the university of Colorado at Boulder to coordinate the implementation of universal newborn hearing screening programs in Colorado and 16 other states. The project is a collaboration between faculty and professionals from The Children's Hospital, University of Colorado Health Sciences center, and the Colorado Department of Public Health and Environment.

The grant establishes the "Marion Downs National Center for Infant Hearing," a center for the promotion of programs for screening, diagnosis and treatment of newborns and infants with hearing impairment. The other states that will benefit from the program include Alabama, Arizona, Arkansas, Hawaii, Kansas, Louisiana, Massachusetts, Michigan, Minnesota, New Mexico, Oklahoma, Rhode Island, Tennessee, Texas, Virginia and Wyoming.

Grenada accreditation standards comparable to US

The U.S. Department of Education has officially notified Grenada that the standards by which it accredits the School of Medicine at St. George's University are comparable to MD programs in the US. Grenada was one of four countries in the world that has been so identified. The other countries are Australia, United Kingdom and Canada.

The National Commission for Medical Education and Accreditation (NCFMEA) has evaluated accreditation standards that apply to foreign medical schools seeking to become, or remain, eligible to participate in the Federal Family Education Loan Program since its inception in 1994. NCFMEA assures that federal loans supported by taxpayer dollars only go to foreign medical schools that provide a high quality education to its students.

WIM leadership conference to "recapture the art of healing"

The CMS Women in Medicine (WIM) section will hold a leadership conference in Denver on April 19, 1997. Entitled, "Recapturing the Art of Healing," the program will feature keynote speaker Clydette Stulp who will discuss the need for doctors to address patient interests in alternative medicine. Richard D. Krugman, MD, dean of the University of Colorado School of Medicine, will explore creative solutions to medical school and residency debt. Workshops on leadership skills, communication techniques, advocating for patients in a managed care settings, and universal health care systems will challenge and interest participants.

For registration details please call Cindy Wooley at the CMS offices at (303) 930-0419.

Level II Physician Accreditation and Re-Accreditation Seminars

The Colorado Department of Labor and Employment, Division of Workers' Compensation, will present Level II Physician Accreditation and Re-Accreditation seminars in the spring and fall of this year.

The Level II Accreditation Seminar is a series of lectures and workshops led by specialty experts on formulating impairment ratings utilizing the American Medical Associations (AMA) Guides to the Evaluation of Permanent Impairment, Third Edition, Revised. The program also outlines pertinent administrative and legal aspects of the Workers' Compensation system.

Scheduled dates and locations are: April 4-5, Hilton Hotel, Grand Junction; September 12-13, Antlers/ Double Tree Hotel, Colorado Springs. The cost of the seminar is $375.00. Call (303) 575-8756 for details.

The Level II Re-Accreditation will be held on May 30-31 at the Holiday Inn/Downtown Denver. The May seminar is for physicians who were originally accredited during the period of May 1, 1993-December 31, 1993. Level II accredited physicians must attend the seminar in order to continue performing impairment ratings for work-related injuries.

Level II physicians that must be re-accredited have been sent registration materials. Because the May 30-31 seminar will be the only one offered, doctors who need to be re-accredited prior to May 1, 1997 will have to complete a home study program. Call (303) 575-8756 or 575-8763 for more information.

9Health Fair

The 18th annual 9Health Fair will be held on April 5-13. The fair has become a mainstay event for many patients throughout the state because they receive basic health screenings and education.

The 9Health Fair has been successful over the years for a number of reasons. The large amount of physician support and volunteerism has definitely helped to sustain this valuable program. Patients can receive free basic health screenings at more than 100 sites around the state. Some physicians are suggesting that patients have an optional thirty-three component blood chemistry analysis done at the fair. These blood reports are cumulative for three years, which assist physicians in tracking their patients' health. Other supplemental screenings are also available.

Sponsors of the 9Health Fair include Centura Health, United HealthCare, 9News, Lions Clubs of Colorado, and the Colorado National Guard. The fair is officially endorsed by the Colorado Medical Society.

Physician volunteers are needed statewide. Generally time commitments are for a morning, weekday on weekend day. For more information, please contact the Colorado Medical Society at (303) 779-5455 or 1-800-654-5653, Ext. 2418 or 9Health Fair at (303) 698-4455.

Dr. VanderArk awarded Business Person of the Year

CMS President-elect Gary VanderArk, MD, was named Business Person of the Year by the Englewood Rotary.

Dr. VanderArk was nominated by Englewood Rotary member Frank Sargent, MD. Dr. VanderArk successfully passed the Rotary's "Four-way test". The test is based upon a business leaders principles and actions, specifically: truth, fairness, attempts to promote good will and better friendships, and provide beneficial service to all concerned. The "Four-way" test embodies the spirit of the Rotary.

Former CMS President, and founding member of the Englewood Rotary, Dr. Gatewood Milligan presented Dr. VanderArk with the award.



Former CMS President Gatewood Milligan, MD, (left) presents Dr. VanderArk the Rotary Business Person of the Year Award.

CMS Alliance places in the top ten for AMA-ERF fund-raising efforts

Over the past year the Colorado Medical Society Alliance (CMSA) dramatically increased fund-raising efforts for AMA-ERF. The alliance revved up its fund-raising machine to increase contributions by 23% over last years numbers. Colorado's total AMA-ERF contribution for 1995-1996 was $24,916.13, an increase of $5,495.47 over last year.

The laudable effort placed the Alliance in sixth place among Alliances in the nation for greatest increase over last year.

CMSA President Stella Shanks noted that the fund-raising efforts reflect a genuine commitment to medicine in Colorado. "I would like to sincerely thank all of the physicians, and medical families for their generous and continuous support of this very important project," she said.

Fund-raising efforts are under way for this year. Hopefully, the strong showing of support last year will continue.

To make contributions to AMA-ERF please mail your check to: Jo Netz, 410 Kendall St., Lakewood, CO 80226. Be sure to submit your name and address, and indicate whether you want the donation to go to the University of Colorado School of Medicine, the Medical Student Assistance Fund, or the Medical School Excellence Fund.

Editor's Note:

So often, older persons have special physicial or social requirements which are not fulfilled through ordinary care agencies. Because of theinfirmaties of age, many persons, even though they are "private pay" patients, do not know where these special services can be found.

Every practicing physician, sooner or later, will be affected by contact with persons who are underserved or need special service, either of a social or medical nature. The Denver Regional Council of Governments (DRCOG) is a coalition of metropolitan area city and county governments, has made available a Directory of various service agencies which focus on the needs of persons 50 years of age or older. We feel that this Directory should be in the hands of as many physicians as possible, and hope that you will keep this for future reference.

Even though DRCOG is obviously working in a large metropolitan area, rural physicians will find aid in this book as well, because the Directory indicates in what agency many statewide social services are located, i.e., county agencies, etc.

Since the Metropolitan Denver area (8-counties) represents over 60% of the state's total population, we felt the reprinting of this Directory quite appropriate.

RESOURCE DIRECTORY

for persons 50 years of age or older

Provided by:

The Denver Regional Council of Governments (DRCOG)
Aging Services Division, Lisa Brabo, Director
2480 West 26th Avenue, #200B • Denver, CO 80211-5580 • (303) 455-1000

INFORMATION AND REFERRAL

AARP	830-2277
Adams County/Senior Hub, Inc.	426-4408
Arapahoe County/Aurora Senior Link	361-2902
Clear Creek County/Project Support Senior Center	1-303-567-2382
City & County of Denver/Denver Commission on Aging	640-2621
Douglas County/S.O.S.	660-7519
Gilpin County/Project Support Senior Center	1-303-567-2382
Jefferson County/Seniors' Resource Center	238-8151
Colorado Dept. of Human Services	866-5700
Aging and Adult Services	629-4147
DRCOG Aging Services Division	455-1000
National Eldercare Locator	1-800-677-1116
Senior Information Source	561-2288
Seniors! Inc. Help Program	832-5565
Volunteers of America Over 60 Services	297-0408

ADULT DAY PROGRAMS

Adult Day Enrichment Program (Multiple Sclerosis Community Resources)	433-6887
Country Garden	750-8418
ElderCare of Calvary Baptist Church	756-1582
Eldership Adult Day Program	450-5188
Highland Club	360-5118
Impact on Wellness	430-9015

Laradon Hall 296-3444
Littleton Manor 798-2497
Morning Star Senior Day Program 361-0898
Provenant Senior Day Program 422-9000
Senior's World 758-3221
Senior's Choice Adult Day Program 360-6600
Seniors' Resource Center/Day Break Adult Day Programs 238-8151
DayBreak/Mountain Services 674-2843
Total Longterm Care 839-7540

CONSUMER AFFAIRS/LEGAL ASSISTANCE

Better Business Bureau 758-8200
Consumer Confidence Rated Businesses 233-6664
Consumer Credit Counseling Service 750-2227
Economic Crime (D.A.'s office for Denver) 640-3557
Guardianship Alliance of Colorado 423-2898
Landlord/Tenant Disputes (Community Housing Services) 831-1935
Legal Aid of Metro Denver ..... (V/TDD) 837-1313
Seniors' Resource Center/Legal Assistance Program 238-8151
U.S. Office of Consumer Affairs
(Private business and government agency complaints) 1-800-664-4435

ELDER ABUSE

Adult Protection ..... . Call the county department of social services
Elder Abuse Prevention Program (Community Housing Services) 831-4043
Victims Service Center Hotline ..... 894-8000 or (V/TDD) 860-9555
Adult Protection Information 1-800-773-1366

EMPLOYMENT PROGRAMS

AARP Works 763-6683
AFL-CIO/Governor's Job Training Office Rapid Response 433-1200
Arapahoe/Douglas Employment and Training 752-5820
Colorado Job Service Center 830-3000
Denver Indian Center 937-0401
Fifty-Five Plus Seniors' Resource Center 235-6958/235-6945
Jefferson County Employment and Training Program 271-4600
Job Service Centers 830-3000
Seniors! Inc. 832-5565
Senior Skills 756-4440
Servicios De La Raza 458-5851

FINANCIAL/EMERGENCY ASSISTANCE

Association of Senior Citizens 455-9642
Catholic Charities and Community Services 388-4435
County Departments of Social Services:
Adams County Social Services 287-8831
Arapahoe County Social Services 795-4850
Clear Creek County Social Services 534-5777
Denver County Social Services 727-3666
Douglas County Health & Human Services 688-4825

Gilpin County Social Services 1-303-582-5444
Jefferson County Social Services 277-1388
Denver Emergency Repair (Furnace, electrical, etc., Denver residents) 534-3872
Denver Indian Center 937-1005
Inter-Faith Task Force 789-0501
LEAP (Heating bill assistance) Call the County Department of Social Services
Lutheran Family Services 933-3433
Salvation Army 295-3366
Red Shield Center 295-2107
Senior Answers and Services 333-3482
Senior Hub 426-4408
Seniors! Inc. (Money Management Program) 832-5565
Seniors' Resource Center/Social Work Program 238-8151
Seniors' Resource Center/Mountain Services Program 674-2843
Servicios De La Raza 458-5851
Social Security and SSI Information 1-800-772-1213
Veterans' Affairs 894-7474
700 Club Operation Blessing 431-8295

HEALTH

Alzheimer Association 813-1669
American Cancer Society 758-2030
American Diabetes Association 778-7556
American Heart Association 369-5433
American Lung Association 388-4327
Arthritis Foundation 756-8622
Colorado AIDS Project 837-0166
Parkinson Association of the Rockies 830-1839
Rocky Mountain Stroke Association 782-5831

Dental Services

Arapahoe County Senior Dental Program 341-9370/761-1340
Dentistry for the Handicapped 298-9650
Denver General Hospital Dental Clinic 436-6440
Jewish Family Service 759-4890
Johnson Clinic 832-6069
Salud Clinic (Commerce City) 286-8900
Senior Answers and Services (Old Age Pension Dental Program) 333-5514
University of Colorado Dental Clinic 270-8752

Health Clinics

Adams County/Salud Clinic 286-8900
Arapahoe County/Littleton Clinic 794-9216
Clear Creek County:
Chicago Creek Clinic 1-303-567-9201
Clear Creek Nursing Service 1-303-569-3251
Columbine Family Health Center 1-303-582-5276
Denver, City and County of:
Denver Department of Health and Hospitals (Senior Plus services) 436-7111
Gilpin County Columbine Family Health Center 1-303-582-5276
Jefferson County/Jefferson County Health Department 232-6301

Johnson Clinic/Medical Care and Research Foundation 831-0267
Metropolitan Denver Provider Network (Aurora) 343-6130
P/SL Senior Citizens Health Clinics 869-2269
Provenant Senior Health Center 825-1234
SAGE Clinic (St. Joseph Hospital) 764-2000
University of Colorado Health Sciences Center 399-1211

Hearing

Center for Hearing, Speech and Language 322-1871
Center on Deafness 839-8022
Denver Ear Institute 788-7766
International Hearing Society 1-800-521-5247
National Hearing Aid Bank (Hear Now) 1-800-648-4327
Relay of Colorado (Communication relay) 1-800-659-3656
VOA Deaf Communication Center ..... (V/TDD)295-1872

Hospices

Community Hospice 293-2273
Hospice of Metro Denver, Inc. 321-2828
Hospice of Peace 575-8393
Hospice of St. John 232-7900
Lutheran Hospice Care 425-8000
Mt. Evans Home Health Care (Evergreen) 674-6400
Porter's Hospice 871-0835
Visiting Nurse Association Hospice 757-6363

Medical Equipment Lending

Assistance League of Denver 322-1688
Association of Senior Citizens 455-9642
Colorado Easter Seal Society 233-1666
Senior Hub 426-4408

Mental Health

Adams County Community Mental Health Center 287-8001
Arapahoe/Douglas County Mental Health 779-9676
Aurora Community Mental Health Center 693-9500
Mental Health Corporation of Denver 757-7227
Jefferson County Center for Mental Health
(Jefferson, Clear Creek, and Gilpin counties) 425-0300
Asian/Pacific Center 393-0304
Mental Health Association of Colorado 377-3040
Servicios De La Raza 458-5851
Support groups (Call for information) 455-1000

Prescription Assistance

AARP Pharmacy Service 1-800-477-7427
Aurora Inter-Church Task Force (Aurora residents) 360-0260
Healthco Solutions (Respiratory drugs only) 1-800-952-1445
National Pharmaceutical Program (Call for information) 455-1000

Vision

Colorado Elderly Blind Rehabilitation Service 937-1226
Colorado Optometric Center 295-2402
Colorado Talking Book Library 727-9277
Families of the Blind 433-1500
Foundation Fighting Blindness 364-4332

National Eye Care Project 1-800-222-3937
University of Colorado Eye Clinic 270-7147

HEALTH INSURANCE

Colorado Insurance Commissioner 894-7499
Medicaid Eligibility Call county department of social services
Medicare Part B claims:
Denver 831-2661
Outside of Denver 1-800-332-6681
Medicare Entitlement/Appeals ..... 1 -800-772-1213
Medicaid/Medigap Insurance Counseling (Centura Health insurance Counseling) 899-5151

HOME AND RESPITE CARE

Call for information 455-1000

HOME MAINTENANCE

Brothers Redevelopment (Home weatherization/improvement) 202-6340
Senior Hub (Adams County/Senior Solutions Mini-Home Repair) 426-4408
Seniors! Inc. Handy Van 832-5565

HOUSING

Elderly Housing CHOICES (Community Housing Services) 831-4046
Long-Term Care Facilities (DRCOG Long-Term Care Ombudsman program) 455-1000
Senior Housing Options 595-4464
Senior Support Services (Elderly homeless/emergency shelter) 832-1622

INCOME TAX PREPARATION

AARP (Call for site locations) 830-2277
Adams County Income Tax Assistance 654-6163
Colorado Department of Revenue (State tax information) 534-1209
IRS (Federal Tax Information) 825-7041
Seniors' Resource Center/VITA (Volunteer Income Tax Assistance) 238-8151

LONG-TERM CARE/SINGLE ENTRY POINTS

Long-Term Care Facilities/DRCOG Ombudsman Program 455-1000
Single Entry Point for Adams County:
Adams County Department of Social Services 289-6663/289-6405
Single Entry Point for Arapahoe/Douglas Counties:
Home Care Management 738-0720
Single Entry Point for City and County of Denver:
Home Care Management 863-1665
Single Entry Point for Clear Creek/Gilpin Counties:
Adult Care Management, Inc. 439-7011
..... Outside Denver -1-800-576-6111
Single Entry Point for Jefferson County:
Jefferson County Social Services 277-1388

NUTRITION/MEALS

Emergency Food Assistance (Call for information) 455-1000
Food Bank of the Rockies 371-9250
Food Stamp information Call county department of social services
Seniors! Inc. Meals on Wheels 832-5565

Seniors' Resource Center/Mountain Services Program 674-2843
SHARE Colorado Program 428-0400
VOA Dining Centers/Meals on Wheels 294-0111

ORGANIZATIONS FOR SPECIAL POPULATIONS

AARP Rainbow Chapter 321-3859
Asian/Pacific Development Center 355-0710
Denver Indian Center 936-2688
Gay, Lesbian, Bisexual Community Center 831-6268
Linkages for Older Adults 322-5601
Jewish Family Service 759-4890
Senior Support Services (Homeless older adults) 832-1622
Servicios de la Raza 477-3817

SENIOR CENTERS

Adams County

Aurora Senior Center 361-2902
Brighton Senior Center 659-4050
Broomfield Senior Center 469-0536
Commerce City Community Center 289-3764
Northglenn Senior Citizens Center 450-8801
Salvation Army-West Adams 428-6430
Senior Hub 426-4408
Thornton Senior Center 538-7320
Tri-Valley Senior Citizens Association 769-4234
Westminster Community-Senior Center 426-4310

Arapahoe County

Aurora Senior Center 361-2902
Littleton Community Center 794-9216
Malley Senior Citizens Center 781-5508
Tri-Valley Senior Citizens Association 1-303-769-4234

Clear Creek County

Project Support Senior Center 1-303-567-2382

Denver, City and County of

Ash Grove Recreation Center 753-9830
Athmar Recreation Center 937-4636
Barnum Senior Center 937-4655
Berkeley Senior Center 458-4870
Carl Park Recreation Center 477-9251
College View Recreation Center 937-4633
Cook Recreation Center 692-5659
Curtis Park Community Center 295-2399
Denver Indian Center 934-8429
Eisenhower Recreation Center 692-5650
GANAS Community Center 893-5114
Glenarm Recreation Center 295-4475
Harvard Gulch 698-4999
Highland Senior Center 455-9835
Jewish Community Center 399-2660
Johnson Recreation Center 295-4477

La Alma Recreation Center 572-4790
La Familia Recreation Center 698-4995
Martin Luther King Center 331-4034
Montbello Recreation Center 373-8710
Mulroy Neighborhood Center 892-1540
Our Savior's Senior Center 831-7023
Park Avenue Center 839-3625
Parks and Recreation Department, City and County of Denver 331-4032
Platt Park Senior Center 698-4965
Quigg Newton Center 458-4873
Red Shield Salvation Army 295-2109
St. Charles Recreation Center 295-4462
Schlessman Family YMCA 757-8484
Senior Support Services 832-1622
Skyland Recreation Center 331-4037
Sunset Park Senior Center 297-0408
Swansea Recreation Center 295-4434
Twentieth Street Recreation Center 295-4430
Walsh Senior Center 935-1211
Washington Park Community Center 733-4643
Westwood Community Center 922-7701
Zion Senior Center 333-5746

Douglas County

Castle Rock Senior Center 688-9498
Parker Senior Center 841-5370

Gilpin County

Gilpin County Council on Aging 642-3252

Jefferson County

Broomfield Senior Center 469-0536
Clements Community Center 987-4820
Evergreen Recreation Center 674-6441
Foothills Park and Recreation District 987-3602
Golden Community Center 384-8130
North Jeffco Senior Center 425-9583
Seniors' Resource Center 271-4700
Seniors' Resource Center/Mountain Services 674-2843
Wheat Ridge Community Center 422-0800

SERVICES FOR PEOPLE WHO ARE DISABLED

Center for People with Disabilities 442-8662
Denver Commission for People with Disabilities 640-3056
Handicap Placards/Colorado Motor Vehicle Department 623-9463
Legal Center for People with Disabilities 722-0300

TELEPHONE MONITORING

Daily Phone Contact 347-1824
Douglas County Senior Services 688-4858
Health Watch 407-994-6699
Integra Services Group, Inc. 470-3929
LifeGuard, Inc. 795-1113

Lifeline 1-800-451-0525

TELEPHONE MONITORING (Continued)

Personal Alert 377-0263
Quick Call 457-1294
Salvation Army 861-4833
TelCARE Systems 756-8000
Visiting Nurse Association 757-6363
Washington Park Community Center 733-4643

TRANSPORTATION

Adams County:

Broomfield Senior Center 469-0536
Metro Mobility 629-5048
Salvation Army 428-6430
Tri-Valley Senior Citizens Association 1-303-769-4234

Arapahoe County:

Arapahoe County Transportation Services 730-1400
Aurora Senior Center 361-2902
Littleton City Government - Omnibus/Shopping Cart 795-3700
Health One Transportation 788-4884

City and County of Denver:

Metro Mobility 629-5048

Clear Creek County:

Volunteers of America 1-303-567-2382

Douglas County:

Castle Rock Senior Center 688-9498
Parker Senior Center 841-5370

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RUMINATIONS

(**def:** chewing again what has been chewed slightly and swallowed; to **REFLECT**)

*by **Bill Pierson**, Managing Editor*

"So, what can the doctor do to get the patient back?"

Did you ever try to train a dog? Notice, I said "try". It's the only association I know when it comes to training: I tried, but I never got close to training anything, at least not the way I wanted it to react.

People are a lot like dogs when it comes to training: they usually behave in an almost opposite manner from how you were trying to train them to behave.

Doctors have been applying their own people-training for a long time: "When you hurt or think you are ill, come and see me. I will work my hardest to make you well".

When people get a dog they seldom think beyond the aspect of the "warm fuzzies" that a growing, living pet brings with them. They don't think about what the dog's life is going to be like; attached to a leash when you get a walk, left alone most of your life, with no other dog for play or communication, waiting expectantly for your next meal or someone to acknowledge your existence, being left to the vagaries of the weather without shelter, or being locked inside, out of the vagaries of the weather, punished when you take out your frustrations on someone's slipper or coat, punished when you forget your training (if you ever accepted any) and messed up the living room carpet, yelled at when you climb onto the upholstered furniture, or jump on someone's clothing when screaming for attention or affection.

Maybe I got a little carried away with my description, but it is all true. We work to train the dog, but we merely train the dog to react to our commands, usually opposite to what we were commanding. And then... when we have the training regimen in place, someone else comes along and suddenly the dog has forgotten everything you taught him/her.

I remember my favorite dog. I worked and worked on training him. I thought I was making great headway until, one day, the garbage collector came along.

My dog, Beau (short for Beauregard) was out in the back yard. The garbage truck came down the alley. Beau caught a whiff of all that good garbage and when the man came through the gate, Beau was out and ready to go to the end of the earth with that ripe smelling truck and driver.

All of his training went right out the back gate with the garbage, all the fault of that "third party".

Patients are a lot like that nowadays, but the consequences are slightly different. We seemed to be getting along fine with our doctors until "Insurance" came down the street, opened the gate, and said to the doctor "We're going to take all the collection burden off your shoulders; you just take care of the patients and leave the money problems to us". Despite all the doctor's training, the patient followed "Insurance" right out the gate and down the street, probably never to return. The deal smelled too good, until they found out they didn't have a doctor of their own any more.

So, what can the doctor do to get the patient back? Not much! You start calling him/her and it doesn't work; he/she doesn't trust this deal or the doctor at all.

It reminds me so much of my favorite dog story... told to me by the late Jack Vance, the pioneer President of Colorado Blue Cross/Blue Shield.

When he was a boy of 8 or 9, Jack had a mongrel dog pet, and this dog was forever chasing cars (the Model "T" era), biting at their tires. Jack's dad told him he had to train that dog not to chase cars. Jack said "How do I do that?" His dad said to come out to the street with the dog and he'd show Jack how.

They went to the street, and soon a car came by; the dog took off barking snarling and biting at that car's tires. Jack's dad said "OK, Jack, now you call your dog back here". Jack whistled and the dog came running to him. When he got close enough, Jack's dad picked up a big stick and whacked the dog, hard, across the rump.

Jack said the training worked, in a manner of speaking: the dog learned that no matter how loud Jack whistled, the dog never came to him again.

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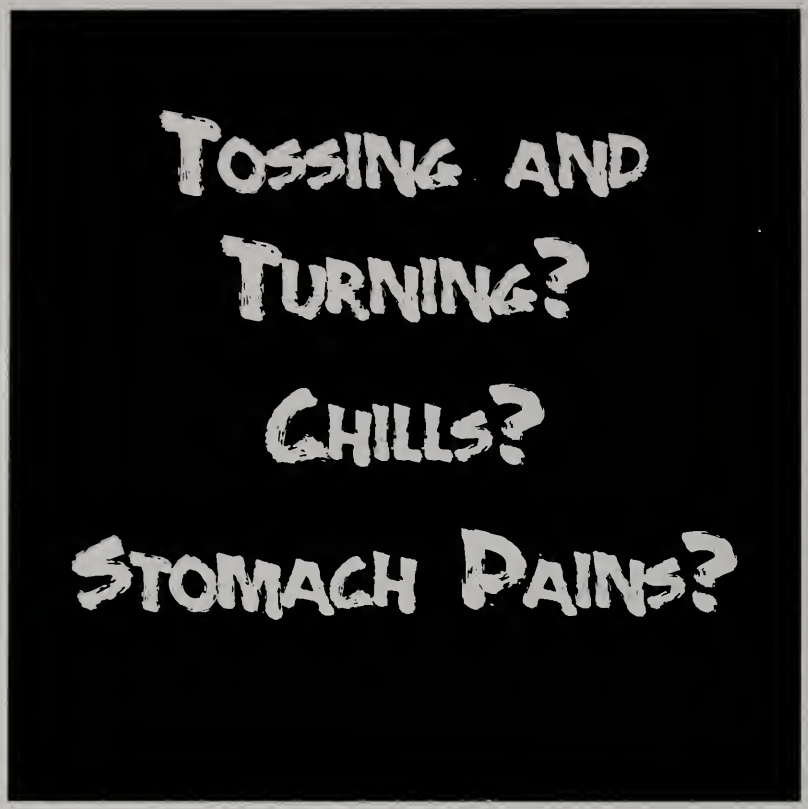
In honor of. . .



John Muth, MD, (left) retiring Director of the El Paso County Health Department, receiving an award for his long service to Colorado's medically indigent. The award was presented by CMS President-elect Gary VanderArk, MD, at the conclusion of a full day conference on "Care for Colorado's Medically Underserved". (See page 159)

n This Issue:

A bright future for medicine by M. Ray Painter, MD ..... **page 137**
Colorado State Hospital by John L. Lightburn, MD, Historian ..... **page 151**
Western Slope and the FTC by W. George Shanks, President, Mesa Co. Med. Soc. ..... **page 143**
Drug Interaction Software- Part II: What is it? by Michael Victoroff, MD ..... **page 165**
What's In A Bottle? Ruminations Proprietary/patent medicine vs. ethical medicine .... **page 170**



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APRIL, 1997 VOLUME 94, NUMBER 4



Cover Story

Dr. Gary Vanderark or Dr. John Muth? It's hard to tell who is happier about the success of the *Caring for Colorado's Underserved* Conference. See page 159.

In This Issue...

137 House of Delegates Presidential Address: March 8, 1997
M. Ray Painter, MD
President, Colorado Medical Society

143 **Evolution of an IPA**: Mesa County and FTC go head to head over Western Slope IPA.
by George Shanks, MD

145-147 **Special Section**: The 1997 CMS Interim Meeting.

151 **The Colorado State Hospital**: An intriguing look at one of the first institutions to serve those who fall under the care of the state.
by John L. Lightburn, MD, Historian, Colorado Medical Society

156 **The focused medical review**: Fraud and abuse are hot topics among Medicare administrators. Find out how Colorado directors are reviewing your practice.
by Grant Steffen, MD
Medicare Medical Director for Colorado

164 **Resurgent professional**: A patient driven adjustment is coming to health care systems near you. Dr. Jack Lewin believes that the time is right for doctors to effectively address the big issues.

165 **Drug interaction software – Part II**: The potential of these applications is great, however you must be aware of some of the shortcomings.
By Michael S. Victoroff, MD, Chair, CMS Committee on Medical Informatics

168 **Building grassroots support**: CMSA "Day at the Capitol" continues to create the foundations upon which legislative relations can be formed.

DEPARTMENTS

137 President's Letter
139 Executive Director's Update
140 The Lobby
148 Board Highlights
150 Copic Comment
151 Archives
155 Colorado Physician's Network
169 Classifieds
170 Ruminations

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Sandra L. Maloney, Executive Editor; William S. Pierson, Managing Editor; Chet Seward, Administrative Asst.

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President's Letter



M. Ray Painter, MD
President, 1996-1997

The Colorado Medical Society is a society of which you should be proud! We're on the right track - doing good things.

CMS has a Dual Mission - Patient Advocacy and Physician Representation and Support. One is not adverse to the other. These charges are not mutually exclusive.

1. Patient Advocacy - At the top of our list!

- **Care of the Medically Indigent** The meeting on Friday, March 7th, on Care for the Medically Underserved, made you feel good to be there, proud to be a member of CMS. With the help of COPIC Insurance, CMS President-elect Gary VanderArk organized and executed a plan that will be very beneficial for the medically underserved in Colorado.
- **Colorado Rural Outreach Program** The C.R.O.P. program is a CMS project designed to assist rural communities with recruiting and retaining physicians.

2. Physician Representation and Support - These are tough times for physicians! This is an area I think CMS can improve upon, and we are exploring a number of possibilities for further assisting our membership with the transitions in medical practice.

CURRENT CMS ACTIVITIES

There's a lot of opportunity for CMS. Here are a few examples:

1. Long Range Planning - We need to know where we're going and how to get there. We're very pleased that Barbara Reed has accepted the challenge of heading up Long Range Planning. This committee has been structured to operate as an ongoing CMS function. The component societies have assisted in developing an excellent group!

2. Collaborative Committee - We've established a forum for negotiating answers to specialty society discord, before divisive input goes to the Statehouse or the press. CMS should be the umbrella organization to enable rational discourse.

3. Legislation - Almost all of our CMS efforts in this arena amount to patient advocacy. Our legislative staff, our lobbyists, and your legislative council continue to do an excellent job. A series of task forces have been set up to work on the issues affecting our membership. We've been successful in bringing more physicians with specific expertise to testify at the Statehouse this year.

4. Information for Physicians' Offices CMS is making progress, identifying benefits and services that will be of value to us. Our keynote speaker, Dr. Kathleen Weaver, past-president of the American Society of Internal Medicine, addressed the subject of electronic medical records.

5. Communications - The CMS web page is up and running! Through e-mail and faxes, CMS will provide you with the summarized information you need, with quick identification of subject matter of interest and concise reports.

"STATE OF THE SOCIETY"

March 8, 1997

Excerpts from Dr. Painter's address to the Interim Meeting of the CMS House of Delegates, March 8, 1997.

(Continued on following page)

"SHIFT HAPPENS" - No question about it, it's happening to all of us right now. Physicians are presently a commodity; we're being bought, sold and contracted for - all at the **lowest price!**

- We're experiencing chaos, and it will get worse, but I think that circumstances will rally the medical profession.
- Physicians are now motivated to unite. We have the clout, we have the resources, and we have the smarts! In CMS we have an organization that can help us do that.

PATIENT POWER - This is our way to regain control.

- The patient will eventually be in control of the health care system. In any free market system, the consumer inevitably has control. We already see this trend in the Legislature - the patients are "calling the shots."
- To improve the healthcare system, we have to be sure that we are in the patient's corner. Our patient has to be our partner. The role of physicians in the era of "patient power" is to practice professionalism, treating our patients with dignity and providing quality care. Let nothing stand in the way of quality care!
- Finally, we need to be organized, with a plan prepared, for recreating a healthcare system that we can be proud of in the future.

I told the story at the Annual Meeting, and I'm going to repeat it here... about the Denver Broncos in the last two minutes of that Cleveland game where Denver was backed up against their own goalposts on about the 2-yard line. In the huddle, Keith Bishop said "We've got 'em right where we want 'em." And Denver went on to score and win that game.

Well, we've got them right where we want them. Let's go get 'em!

LEGAL UPDATE

from Gelt, Fleishman & Sterling P.C.



A. Craig Fleishman, Managing Director

Entities and the Attorney Client Privilege

Part 1

Almost everyone has some level of familiarity with the attorney-client privilege. In the movies or on television we see a client baring his soul to his attorney with the understanding that the secrets revealed will never be disclosed to anyone. In reality, the attorney-client privilege does not operate so simply. The question of who may assert the privilege becomes more complex when professional associations or other entities are involved as the client is no longer a single individual. The client is instead made up of many voices, ranging from executives, managerial employees, and staff persons to association members. When will communication be protected by the attorney-client privilege and who among this group can participate in a privileged communication.

Basically, several factors determine whether a particular communication may qualify for the protections afforded by the attorney-client privilege. In order for communication to be protected, the communication must be: 1) *Between an attorney and his or her client.* The attorney and client must have a formal professional relationship for the privilege to be invoked; 2) *Confidential.* The information must not be disclosed to third parties or disclosed to the attorney in the presence of persons not associated with the attorney or the client; 3) *Obtained for the purpose of seeking legal advice.* The information conveyed to the attorney must relate to the legal services the attorney is being asked to provide; and 4) *Not in furtherance of a fraud or tort upon another.* The privilege will not protect anyone who seeks advice on how to commit a crime or other legal wrong.

These four points identify the characteristics of a protected communication, but who can assert the attorney-client privilege when the client is an entity instead of a single individual? Association or corporate counsel will often find it necessary to speak with a wide range of employees when investigating or handling a legal matter. Communications may range from tactical discussions with the entity's chief executive officer to conversations between an attorney and an association secretary concerning the handling of documents or implementation of association policies. If the communication satisfies the four previously mentioned criteria, will it be protected no matter with whom the attorney is speaking?

Courts have generally analyzed attorney-client privilege issues involving entity clients under either the "Control Group Test" or the "Subject Matter Test." These "tests" will be discussed next month.

For further information contact:
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by ***Montgomery Little and McGrew, P.C.***
legal counsel to the Colorado Medical Society

CMS seeks legislative clarification on BME action...and gets it

On Monday, March 17, Robert B. Sawyer, MD, testifying on behalf of the Colorado Medical Society (CMS), asked the House HEWI Committee to clarify if the legislature believes it is appropriate for physicians to be required to report their colleagues to the BME for violations of the Medical Practice Act. If the committee thought that physicians should be required to report, HB 1327 (Rep. Joyce Lawrence Senator Dottie Wham) would have provided certain exemptions from the requirement. Those exemptions included: 1) the physician - patient relationship (when a physician is treating an impaired physician); 2) physicians with physical or mental disabilities in a treatment program such as CPHP; and 3) peer review. If the committee thought that physicians should **not** be required to report, CMS would have clear legislative intent that physicians were not subject to disciplinary action for failure to report. The House HEWI Committee said "no", and killed the bill.

In May 1996, an article titled "Fact and Folklore of Reporting Physician Misconduct to the Medical Board" appeared in *The Colorado Lawyer*. The article was written by Matthew Norwood, Assistant Attorney General for the BME "to help attorneys advise their physician and hospital clients when to report suspected physician misconduct to the Colorado State Board of Medical Examiners." Many, including CMS, questioned the accuracy of the interpretation of the reporting obligation in the article.

Physicians who had been disciplined by the BME brought their cases to the attention of CMS staff. Even though legislature explicitly denied granting the BME the authority to discipline physicians for failure to report, and that Department of Regulatory Agencies (DORA) had clearly stated that failure to report carried no penalty, CMS believes that the BME was clearly acting under the interpretation of the May 1996 article by Mr. Norwood. The CMS Board of Directors initiated the process of seeking a declaratory order from the BME to resolve this issue.

Upon hearing that CMS may seek the declaratory order, the BME volunteered to meet with CMS to resolve the issue. Knowing the BME could either 1) refuse to issue an order, or 2) issue an order finding the interpretation of the attorney general's office accurate, CMS settled on the language of HB 1327.

For more information on physician reporting requirements or if you become the subject of an investigation by the BME for failure to report, please contact Suzanne Hamilton, Dept. of Government Relations at 800/654-5653 or 303/779-5455 ext. 427 or contact your attorney.

CMS representative sought for CFTC Board of Directors

The Colorado Medical Society (CMS) is a member of the Coalition for a Tobacco Free Colorado (CTFC). CMS also holds a seat on the CTFC Board. For the past few years, a staff person from CMS's Department of Health Care Policy has represented CMS on the CTFC Board and Coalition. Direct physician involvement is currently needed with the Coalition. For details, contact Suzi Shevell at 303-779-5455 ext. 2407.

CMS Call for Nominations

A call for nominations has been announced, seeking nominees for the offices of Colorado Medical Society President-elect, Speaker and Vice-speaker of the House, and Delegate and alternate delegate to the American Medical Association.

Nominations may be made by CMS members at large, either through component societies, or to the CMS direct. Self-nominations are accepted as well. Nominations must be received by June 1, 1997. Mail the nominating letter and the nominee's curriculum vitae to the: ExecutiveDirector, Colorado Medical Society, P. O. Box 17550, Denver, CO 80217-0550.



Med Fax: Medico-Legal News

by Karen B. Best, Esq., an associate with the law firm of Montgomery Little & McGrew, P.C.

This column contains information concerning topics of general interest in the medical-legal field. For further information or help with specific problems, please contact Montgomery Little & McGrew, P.C.

Comparative or Contributory Negligence

"Comparative or Contributory Negligence." It's a legal defense that comes up in medical malpractice cases when the patient or someone else has done something negligent that contributes to the patient's damages. Patient contributory negligence occurs when a patient fails to do an act which a reasonably careful person would not do, under the same or similar circumstances, to protect him or herself from new or additional injuries, damages or losses.

A patient may be contributorily negligent if the patient fails to follow a physician's advice. For example, a patient comparative negligence would occur if the patient fails to take prescribed medications, or removes a leg cast on the way home from the doctor's office, and the patient's actions lead to new or additional injuries, damages or losses.

Patient contributory negligence may also occur if a physician directs the patient to see a specialist but the patient fails to follow the physician's specific directions.

However, to effectively use patient comparative negligence as a defense, the physician must show that the patient's negligence was related to the physician's treatment and occurred close enough in time that it would not be considered "distinct and remote" to the cause of the patient's injury. Thus, a patient's failure to consult with a surgeon 4 years prior to her death from a condition which likely would have been successfully treated by that surgeon, could not be used as a basis for asserting the defense of patient comparative negligence.

Comparative and contributory negligence are liability concepts which affect the amount of damages a patient can collect. If the jury determines that both the physician and the patient were negligent and that their negligence caused the injury, the jury will then be asked to apportion the degree of negligence between the physician and patient. If the patient's negligence is equal to or greater than the physician's negligence, then the patient will not recover any money. On the other hand, if the physician's negligence is greater than the patient's negligence, the patient will be allowed to recover. If the patient is allowed to recover, the total damages awarded by the jury will be reduced by the Court by the percentage of the patient's negligence.

Reference: Kildahl v. Tagge, No. 95CA1302 (Colo. Ct. App. December 27, 1996)

Legislation

The following is a summary of legislation which may be of interest to the medical community. This summary is not all-inclusive and, in fact, omits other legislation of interest and concern to physicians. These bills are currently making their way through the Colorado House and Senate, but *are not law*.

House Bill 1002: Concerning Civil Liability Relating to Illegal Drugs

Establishes a new cause of action in favor of any person or entity suffering damages or increased expense because of illegal drug use. Specifies that an action may be brought against any person or entity that sold or was in the chain of distribution of the illegal drug used by the individual illegal drug user and any person or entity involved in the sale or distribution of the type of illegal drug used by that individual. Establishes a new cause of action in favor of an illegal drug user against any person or entity that sold or was in the chain of distribution of the illegal drug used by that individual. Sets forth certain exceptions, what damages may be recovered, rules on contributory negligence, contribution among joint tort-feasor, prejudgment attachments, and other procedures. Status of House Bill 1002: Passed House on 2-14. Awaits "Action" in Senate Judiciary.

House Bill 1039: Concerning a Mandatory Waiting Period Before a Health Care Practitioner May Solicit an Accident Victim

Prohibits health care practitioners or their agents from soliciting employment relating to a personal injury for 30 days following the incident giving rise to the injury. Excludes emergency health care services provided at the time of the incident. States that an injured person or his or her representative may deny compensation for services provided by any health care practitioner making a prohibited solicitation. Status: Passed House on 2-11. Assigned to Senate HWX Committee.

CMS Med Fax

Mark your calenders for the CMS Leadership Conference

The 1997 CMS Leadership Conference will be held on May 31-June 1 at the Sonnenlap Resort in Vail. CMS President-elect Gary VanderArk, MD, and the program committe are hard at work to bring you the very best conference. Outcomes measurements will be the topic of discussion this year.

Please fill out the Sonenalp Hotel registration form below, then be on the look out for the conference schedule in next month's editon of *Colorado Medicine*. Be sure to mark your calenders and fill out the hotel registration. All CMS members are encouraged to attend this educational program.

Sonnenalp Resort of Vail

Pre-registration form

Group Name: Colorado Medical Society

Name: _____ Phone #: ( ) _____

Address: _____ City: _____

State: _____ Zip: _____ Number in Party _____

Arrival Date: _____ Departure Date: _____

Credit Card Information:

Please Note: A deposit equal to one night's stay will be charged to your credit card. Balance is due upon check-out.

Check one: ❑ Mastercard ❑ Visa ❑ Diners Club ❑ American Express

Credit Card Number: _____ Expiration Date: _____

Cardholder's Name: _____

Special Seminar/Conference rate will be extended to attendees for longer stays.

Desired Accommodations:–Bavaria Haus Suites: ❑ King Bed ❑ 2 Double Beds

$120 per night, Single or Double Occupancy – Number of Units: _____

Bavaria Haus suites all contain gas-log fireplace, large baths with soaking tub big enough for two, separate shower, heated tile floor, walk-in closet, TV, VCR, fully-stocked mini-bar, hand-carved pine Bavarian furniture, and down comforters on all of our beds.

There will be an additional charge of $25.00 per night for each person over 12 years of age exceeding Double occupancy.

(Note: most suite types cannot accommodate more than 3 adults.)

Reservations received after May 16, 1997, will be taken on a space available basis only.

Cancellation Policy: In the event of cancellation 14 or more days prior to arrival, you will receive a full refund. If you cancel less than 14 days prior to arrival, you will forfeit the deposit of one night room and tax.

Reservations will be taken with this form or call our reservations Department at (800) 654-8312.

Please mail this form to:

Sonnenalp Resort, Attn: Group Reservations, 20 Vail Road, Vail, CO 81657

CMS Med Fax

Colorado Medical Society provides the following listings of events as a member service only. Some events are approved for Continuing Medical Education credits. Information is provided by the sponsoring organizations. For more details, use the telephone contact at the end of the listing.

Colorado Dept. of Public Health & Environment
HIV Prevention Counseling
April 16-17
Pueblo, CO
Contact: (303) 692-2740

Colorado Hospital Association
The Paper Chase: Fundamentals of health care contracts
April 17, 1997
Denver, Colorado
Contact: (303) 758-1630

Dr. Ira Byock
Medical, Legal and Moral Concerns Surrounding the Dying Patient and Family
April 17, 1997
Denver, Colorado
1 hr. of CME credit
Contact: (303) 779-5455 ext. 2425

Colorado Dept. of Public Health & Environment
HIV Prevention Counseling
May 14-15
Denver, CO
Contact: (303) 692-2740

Colorado Dept. of Public Health & Environment
Managing Stress for STD/HIV Professionals
June 3, 1997
Pueblo, CO
Contact: Michael Murphy (303) 692-2766

Leigh Truit, MD, et al.
Leaving the bedside? Yes or no?
June 6, 1997
Denver, Colorado
Contact: Elizabeth Kraft at (303) 333-0900

The Given Biomedical Institute
Genetics Ethics in the 21st Century
July 18-20, 1997
Aspen, Colorado
Contact: Linda Woodstock at (303) 372-9050 or 1-800-882-9153

Colorado Society of Osteopathic Medicine
Annual Meeting
July 25-27, 1997
Vail, Colorado
18 hours AOA category 1-A CME and Physician Asst Crdt.
Contact: Patricia Ellis at (303) 322-1752

America College of Cardiology
11th Annual Echocardographic Symposium on 2-D and Doppler Echocardiography at Vail
July 27-31, 1997
Vail, Colorado
27.5 Category 1 AMA CME credit
1-800-253-4636, ext. 695

Medicine/Pediatrics Physicians Needed to Teach Medical Students and Residents

Physicians who trained in joint internal medicine and pediatrics residency programs are needed teach medical students and residents. The Departments of Internal Medicine and Pediatrics at the University of Colorado School of Medicine offer an elective in community-based, ambulatory internal medicine/pediatrics (two or four weeks) to fourth year medical students. Plans are underway to start a joint medicine/pediatrics residency program in July 1998. If you are med/peds trained and interested in teaching medical students and/or residents, please contact:

Lorraine Adams, M.S.W., Department of Medicine Office of Student Affairs, UCHSC, 4200 E. Ninth Avenue, Box B-166, Denver, CO 80262, (303) 315-6758, Fax (303) 315-6607, E-mail: lorraine.adams@uchsc.edu

CMS Med Fax is printed on recycled paper

Executive Director's Update



Sandra L. Maloney
Executive Director
Colorado Medical Society

Colorado's public health scene, 50 years ago, was a pretty bleak picture, until the entrance of one Dr. Florence Sabin, a plucky little lady who, later in her career, turned Colorado's Public Health system on its ear. It was all for the good of the patient, and Dr. Sabin wouldn't take no for an answer when she said the state laws do not do their job in protecting the public's health.

Sabin's health laws established sanitary standards for public drinking water and milk and other dairy products; they set standards for treatment and disposal of sewage; they put forth procedures for lessening the incidence of tuberculosis; they provided funds for the University of Colorado Medical School to stress public health training; and they centralized all state health functions in the Colorado Department of Health. Those laws also created legal provisions for local health departments.

Say what you want about modern technology and research and medication advancements, improvements in sanitation and environmental conditions in Colorado have shaped major positive changes in public health in the 21st century.

From such medicine has emerged a modern-day hero among physicians and others who care for this population. He is John B. Muth, MD, Director of the El Paso County Health Department.

On Friday, March 7, Dr. Muth received a ***CMS Award in Recognition of Services to the Medically Underserved of Colorado.*** State Senator Sally Hopper received like recognition for her many legislative roles in caring for the medically underserved.

50 years ago, *care for the medically underserved* was practically unknown. Just what does the phrase mean today? It's not simply "public health", it involves the "health of the public". It means care of the low- or no-income persons; it includes the undocumented workers, the uninsured and underinsured; it includes the single-parent children on Medicaid or HHS funding; the mentally ill, the homeless,and others.

Dr. Muth did not set out to be a hero; he did not set out to change the state's policy on caring for this segment of the population. He just wanted to insure all those in need of medical care and treatment received the best possible care and were given the same access to care across the board.

People are still talking about this day-long ***Care For The Medically Underserved*** conference, directed by President-elect Dr. Gary Vander-Ark. Gary's "General" abilities shone through, which made the conference such a success: Gary as the Commanding General, positioned his troops, then fired several salvos from the ranks of highly qualified soldiers who came up out of the trenches from every level of caregivers. As Gary told the audience in his closing remarks, "Every one of you could have been one of the outstanding speakers or panelists today, you are all that good at what you do". He was good at what he did, too. Thanks Gary, and thanks to all your helpers.

National Public Health Week, April 7-13, Celebrating 50 years of progress in public health in Colorado



Florence Rena Sabin, MD,



John B. Muth, MD, Director
El Paso Co. Health Dep't.

The Lobby

by Christopher Unrein, MD, Co-Chair,
CMS Council on Legislation

It has been another active legislative term at the Capitol. Outside forces continue with their attempts to erode the practice of medicine. Five issues in particular come to mind.

First is abortion. CMS does not take a stand on this issue out of respect for the diverse backgrounds and beliefs of its membership. HB 1136, Concerning "Partial Birth Abortion" criminalized a medical procedure. A member of the Council on Legislation testified against the criminalization of a medical modality as a matter of precedent, but she did not take a stand on the abortion component of the bill, as was erroneously reported in local media. I would expect that any similar language in the future will also be strongly opposed, but CMS will continue to take an unbiased stance on controversial/personal issues like abortion.

The "alternative medicine" bill (HB 1183) has created a great deal of fervor. In its original form, this bill created a different standard of care for physicians who practice some form of alternative medicine. As the course of negotiation progressed, CMS and the Board of Medical Examiners withdrew their opposition when the bill was amended to state that a physician would not be disciplined solely for practicing alternative therapies. Language regarding the consideration of risk/benefit ratio was also included in the amendment.

HB 1311 and HB 1161 demonstrate the proactive side of your leadership. HB 1311 deals with disclosure of managed care plan benefits. The bill would create a standardized format comparison sheet to assist patients when choosing a managed care plan. Easy-to-read details about plan benefits allow for accurate comparisons. This is especially important in the senior care area where a patient may be easily confused and lured into something he/she does not understand. HB 1311 is progressing with minimal opposition. HB 1161 is also the result of a resolution from your House of Delegates. It states that negative utilization decisions in the care of patients constitutes the practice of medicine and thereby are ultimately the responsibility of a licensed physician. The amended version of the bill requires managed care organizations, upon request, to make available their standards for utilization review.

HB 1327 is a "late" bill proposed by CMS and sponsored by Representative Joyce Lawrence in response to a broad interpretation of reporting requirements contained in the Medical Practice Act. The CMS determined that this bill is necessary to clarify when a physician must report another physician. The bill will exclude from reporting requirements (1) peer review activities; (2) reporting of physicians involved in the Colorado Physicians Health Program (unless the physician drops out of the program) and (3) physicians treating other physicians unless that physician is a threat to himself of his patients.

The Council on Legislation and CMS leadership are planning to invite legislators to educational sessions about medical practice, scientific methods, and the physician/patient relationship. CMS members will also host one-day mini-internships for legislators. These opportunities are being offered to foster more understanding among legislators that CMS advocates on behalf of patients and does not just fight "turf battles".

"Reclaiming the practice of medicine from the board room and returning it to the bedside is what the legislative council is all about."

This is the first article I have written for *Colorado Medicine* as Co-Chair of the Council on Legislation. My service on the council throughout the past two years has been enjoyable because of our patient and physician advocacy role. Reclaiming the practice of medicine from the board room and returning it to the bedside is what the legislative council is all about. It is also why I look forward to continuing to serve CMS.

Here's Our Agenda

It's simple. It's straightforward. And it represents the future of medicine. The American Medical Association presented to the Republican and Democratic leadership this agenda for the upcoming 105th Congress. Your AMA membership strengthens our voice in support of physicians and their patients. . . and will enhance our efforts to turn these goals into reality.

- **Patient Protections** Above all, preserve the ability of physicians to act as advocates for their individual patients. Do not allow insurers to "gag" physicians or withhold medically necessary treatments from their patients.

- **Medicare Reform** Make the Medicare program solvent. Expand patient choice of plans. Allow future growth rates that cover patients needs. Retain special protection for the vulnerable and elderly.

- **Medical Education and Research** Continue to support medical education and research so we can find cures for killers such as AIDS and cancer.

- **Public Health Problems** Expand prevention and treatment programs to combat AIDS, drug abuse, smoking and violence. These problems cost billions of dollars and millions of lives.

- **Liability Reform** Enact meaningful liability reform to ensure fair compensation to patients with legitimate claims while eliminating excessive malpractice awards that lead to defensive medicine.

Join or renew your membership in the AMA today — call 800 AMA-3211

American Medical Association

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AIR FORCE

Address to the CMS House of Delegates March 8, 1997
by Dr. W. George Shanks, President, Mesa County Medical Society.

I've been in Colorado since 1968, and I practice General Surgery in Grand Junction. I don't think it is an accident that the Colorado Physician Network chose Rocky Mountain HMO to be their third party payer, dealing with the new product that they are providing. It didn't just happen that Rocky Mountain HMO was there. There's a long history of where it came from and how it got to be where and what it is.

The doctors in Mesa County set up the Rocky Mountain HMO in 1973, and it was the seventh registered HMO in the United States. At that time, 90% of the physicians in Mesa County participated with this HMO. The first contract that Rocky Mountain HMO secured was a capitated contract for the Medicaid population. Let me say that again: the FIRST contract was a capitated contract for the Medicaid population. That's what we were then, and that's what we continue to be at the present. Since then, Rocky Mountain HMO has evolved into covering probably 50% of the residents in Mesa County. It includes a significant amount of private insurance along with Medicare. At the time the IPA was started in 1973, it was the Western Slope Physician Association, and it just so happens that the first president of that association was Ray Painter, current CMS President.

Let me tell you a little bit about what we have done during these years.

- We were a pilot project for the Community-wide Health Care Program which was to insure the children of Mesa County. That was a success in Mesa County and has now extended throughout the state.
- We have also been actively involved in immunizations. We provided free MMR vaccinations to the children of Mesa County during a recent measles outbreak.
- Because of the extreme expense of patients in the emergency room, we also set up a program about five years ago where the primary care physicians got together and kept one of their offices open until 9:30 to 10:00 o'clock at night.This was staffed by rotationg the Family Physicians through that clinic. Of course, this drastically reduced the cost of these after-hour visits.
- We are also actively involved in providing, at minimal charge, helmets to children for riding their bicycles.
- We have stopped the tobacco companies from using Grand Junction as a focus for national advertising campaigns.
- We have been actively involved in "B4 Babies" which is an educational program for the young girls in an effort to decrease teen pregnancies.
- We've been actively involved, both financially and in providing physician assistance, in the Marillac Clinic, which is a clinic that provides care for the non-insured.

We were an organization dealing with the only insurance company who was interested in us, and that was the Rocky Mountain HMO. Nobody else seemed to care too much about what we did over there, and so we were pretty much left to do our own thing.

(Continued next page)

"Let me say that again: the FIRST contract was a capitated contract for the Medicaid population."



W. George Shanks, MD
President
Mesa County Medical Society

Interim Meeting 1997 *(Continued)*

In the early 1990s we started to see a plethera of contracts coming in from all sorts of insurance companies, HMOs, etc., and we really didn't know what to do with these. The first thing we thought was that if we were going to sign a contract, we probably ought to read it. As you all know, that can be somewhat difficult, and even after you've finished reading it you are still not really sure what it says.

The membership then requested the IPA to form a contract review committee which would go through the things in the contract that were good or bad for the patients and physicians. I want to emphasize that the purpose was to consider the concerns of both the patients and physicians. It didn't take a rocket scientist, and in fact, I could even look at the contract and figure out what they were going to pay me. That really wasn't the issue. The issue was "What is in this contract that would make my life Hell, or make my office staff jump through a hundred hoops?" What we were looking for were things like gag clauses or hold-harmless clauses. We were also looking at products or insurance coverage that did not cover well-baby care. Additionally, plans were carving out psychiatric so the primary care physicians could not see psychiatric patients. So, what we were basically saying was that if we were going to sign our name to a contract, the patients would then have some assurance that it was a relatively good contract. Apparently, somebody didn't like what we did, and in February of this year I achieved a new title of "Respondent George" to an FTC (Federal Trade Commission) investigation.

In April of 1996, three lawyers from the FTC came out and spent over a week taking depositions from board memebers and past presidents of the IPA. Some of the doctors spent over eight hours in deposition. It was not a really pleasant experience. In December we got our consent decree from the FTC, which basically said "You will cut your physician participation in the Mesa County IPA to 30%." That was to be across the board: specialists and primary care physicians. That seemed to be all right with me, although I had a hard time figuring out how I was going to get two-thirds of Ted Sadler in the cardiac surgery program.

We elected not to sign the consent decree, and with the aid of the Colorado Medical Society, Sandi Maloney, AMA delegates, and especially Dr. David West (a primary care physician in Grand Junction), we were able to talk with the AMA. The AMA sent two lawyers at their expense to interview our IPA Board. They felt that the FTC was a little heavy-handed and agreed to help us in our fight. It was extremely gratifying to have the AMA recognize our efforts as beneficial to both the doctors and patients of Mesa County

What are the conclusions?

I don't think there is any question that we're out of compliance with the FTC. You are just not allowed to have 90-95% of the physicians doing any one thing; however, I am not sure that we can be in compliance with the FTC and continue to deliver the quality of care that we are giving in Mesa County. I think it is critical that Mesa County wins this lawsuit. If we don't it will have a serious negative effect on health care delivery, primarily in rural Colorado, but also in the Denver and metropolitan areas. The FTC is now in the business of determining what is best for you and your patients.

What do I want from you? At the present time I just want your moral support. I want to inform you of what's happening over there. We have spent $125,000 so far, and the meter is still running. I am rather proud of my new title of "Respondent George," and I wear it as sort of a badge of courage, and I think that after listening to Jack Lewin and what he thought was good for medicine in the future, I said ***"we've been there... done that...and we're still doing it."***

I think we have done a good job in western Colorado and I think it is very important that we continue this fight.

–Thank you very much.

DRAMATIC IMPROVEMENT IN TIMELINESS OF INSURANCE CLAIMS PROCESSING . . .

...Or so it would seem from the number of responses the CMS Health Care Financing Department has received from CMS members. Articles appeared in both the January and March 1997 issues of *Colorado Medicine* requesting data which demonstrates insurance processing delays. To date the number of reported problems has not been sufficient to demonstrate any pattern or major concern.

If you don't agree with the opening statement (i.e., improved timeliness) and you happened to miss the articles, please take a minute to read page 108 of the March 1997 issue of *Colorado Mediicine*. If you need a copy of the article please call the CMS Communications Department at (303) 779-5455 or 1-800-654-5653. CMS staff are prepared to address documented problems on several levels, but we need your input.

As they say, *speak now or forever hold your peace...*

Proceedings of the House of Delegates - Interim Meeting 1997

TheColorado Medical Society House of Delegates mat at the Holiday Inn Southeast, Aurora, Colorado, March 8-9, 1997 and took the following actions:

REFERENCE COMMITTEE ON BOARD OF DIRECTORS/CONSTITUTION & BY-LAWS

Adopted a resolution that requests the Colorado Medical Society support the Human Rights Foundation of Turkey.
Adopted a resolution that calls for establishing a committee of the Colorado Medical Society to evaluate the activities and procedures of the Colorado Physician Health Program, Colorado Personalized Education for Physicians, and the Board of Medical Examiners.
Adopted a resolution requesting the Colorado Delegation to the American Medical Association (AMA) ask the AMA to study the use of the term "race" in the clinical context.
Adopted a resolution from Actions of the Board that calls for loaning money to the Colorado Rural Outreach Program (CROP).
Referred a resolution that calls for the formation of a Colorado Medical Society committee to study medical futility in end-of-life care.
Accepted for filing:

Progress Report - Colorado AMA Delegation
Progress Report - Board of Directors
Progress Report - Executive Director
Progress Report - Organizational Study Committee
Progress Report - Historian

REFERENCE COMMITTEE ON HEALTH AFFAIRS

Adopted a resolution requesting legislation in 1998 to amend current Colorado statutes regarding Workers' Compensation. This legislation would maintain employer designation of physician, but also allow the injured employee a greater choice when selecting a treating physician.
Adopted a resolution from Actions of the Board calling for support of the Colorado Medical Society Board of Directors' efforts to clarify physician's reporting requirements to the Board of Medical Examiners for unprofessional conduct.
Adopted a resolution to amend the Financial Incentives Section of the current Managed Care Policy.
Adopted a resolution to support and endorse the American Medical Association's "Medicare Repair Proposal".
Referred a resolution calling for legislative action on a Colorado Medical Society policy that no senior plan formulary be more restrictive that any commercial formulary.
Accepted for filing:

Progress Report - Health Affairs Council
Progress Report - Council on Legislation
Progress Report - COMPAC

Attendees to the House of Delegates Interim Meeting 1997

Arapahoe
Aarestad, Norman
Bartee, Roy
Bartlett, Max
Bublitz, Deborah
Capek, Richard
Dwoskin, Joseph
Frank, George
Gipson, Sheri
Gulevich, Steven
Hammerly, Milton
Jolly, Susan
Knize, David
Kortz, Allan
Lazarus, Jeremy
Levine, Mark
McCarthy, Howard
Stecher, Karl
Stienmier, Richard
Truitt, Leigh
Vernon, Walter

Aurora-Adams County
Gottula, Roderic
Greos, Leon
Heaton, Angeline
Heaton, Carl
Rich, John
Sherman, Eugene
Sherman, Susan
Spaulding, Harry
Sundland, Barry
Unrein, Christopher
Visconti, Paul

Boulder County
Benson, Alan
Berg, Kevin
Carr, Alfred
Curtis, William
Kelley, Severance
Mooney, Herbert
Replogle, Scott
Rupp, Gerald
Stjernholm, Melvin
Wherry, Harry
Zurick, Vernon

Clear Creek Valley
Brundige, Richard
Cedars, Chester
Chambers, Jodi
Cohen, Richard
Doig, William
Eaton, Wyley
Fleischaker, Gordon
Golbert, Thomas
Kief, Jan
Mehra, Promilla
Morse, Marc
Mozia, Nelson
Netz, Howard
Oppenheim, Walter
Parry, Lynn
Sadler, Dean
Sawada, Kathleen
Tarkanian, Malcolm
Tegtmeier, Ronald

CAFP
Page, Patrick

Colo. Chap ACEP
Murphy, Carla

Colo. Chap ACP
Jensen, Jonathan

Colo. Dermatological Soc
Golitz, Loren

Colo. Gyn/Ob Society
Ganter, Debra

Colo. Oto Maxillofacial Society
Conlon, Robert

Colo. Psychiatric Society
Krause, Kenneth

Curecanti
Hopple, Lynwood

Denver
Allen, Richard
Anneberg, Lee
Barmatz, Hirsh
Bogin, Robert
Campbell, David
Corenman, Donald
Foust, Glenn
Hawkins, Joy
Hutchison, David
Illige-Saucier, Martha
Jacobson, Eugene
Kinzie, Jeannie
Koeller, Paula
Lightburn, John
Major, Frank
Manart, Frank
McCafferty, Bonnie
McCartney, Robert
Muftic, Michael
Nelson, Nancy
Rainer, Gerald
Ratzer, Erick
Regan, James
Rhodes, Edward
Sawyer, Robert
Sbarbaro, John
Schemmel, Janet
Schramm, Victor
Stieg, Richard
Stigler, Del
Sullivan, Terrance
Tessler, Heidi
Traylor, Kathleen
Woodard, Donald

El Paso County
Arnold, Hank
Barry, Francis
Brentlinger, Dale
Crawford, Lewis
Emeis, Bill
Feinsod, Fred
Fitzgerald, Edward
Folan, Richard
Johnson, Thomas
Larkin, James
Martz, David
Moore, Larry
Muth, John
Nielsen, Peter
Ogrodnick, John
Pero, Robert
Pollard, Joseph
Pomerenke, Laura
Reynolds, Judith
Rubinow, Sidney
Struck, Teresa

Fremont County
Gamache, Peter

Larimer County
Allen, Thomas
Belleville, Bruce
Carroll, Cory
Tello, Robert
Thorson, Steven
Weiskittel, Deborah

Las Animas County
McFarland, Douglas

Med. Student Component
Abbey, Shawna
Brockmann, Robert
Wallace, Hilary

Mesa County
Hanna, Robert
Sadler, Theodore

Morgan County
Clise, Keith

Mt. Sopris County
Mason, Ronal
Rodriguez, Jose

Northeast Colorado
Bonelli, Joseph

Pueblo County
Drake, Robert
Laman, Muryl
Miller, Roger
Morgan, Alethia
Schaefer, Sharon
Tonsing, Robert
Wilz, William

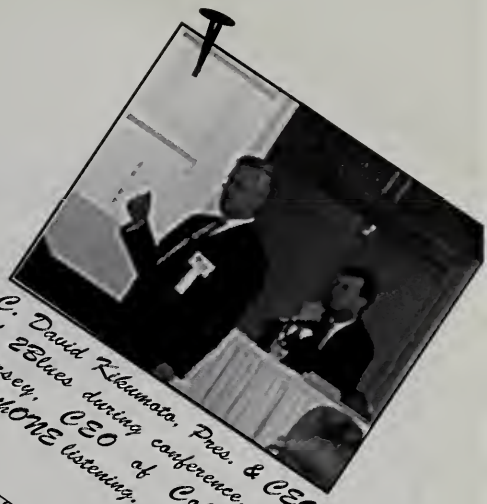
San Luis Valley
Brownrigg, Richard
Culp, Raymond

Weld County
Flower, Thomas

Women in Medicine Sec.
VanScoy, Sarah

152 Attendees

Snapshots: 1997 Interim Meeting & Medically Underserved Conference



C. David Kikumoto, Pres. & CEO of CBlues during conference. Jeff Dorsey, CEO of Columbia/HealthONE listening.

Kathleen Weaver, MD, presented an interesting address concerning electronic files and computerized medical records. Good information and a charming presenter. Dr. Weaver is former President of the American Association of Internal Medicine.



"And here's how the electronic, computerized records system works..."

Senator Sally Hopper receives an award for Outstanding Contribution to Care for the Medically Underserved. Also, Susan McFarlan;, NP, PA, MPH, of People's Clinic of Boulder was recognized for her contributions, but was unable to attend the conference.





"For some reason, the computer is not responding..."



Keith Moore, facilitator for the Friday conference, seemed to be enjoying his work.

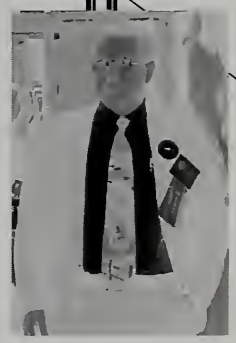
M. Ray Painter,CMS President, repeated his theme for organized medicine in 1997: The future of medical practice is promising, but physicians will have to decide what happens. Dr. Painter helped the two day meeting stay on an up-beat.

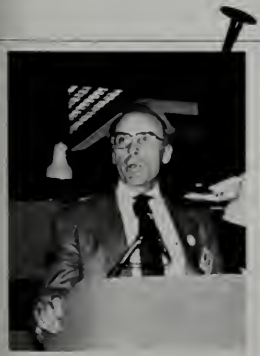


Well, you'll have that, even with computers.

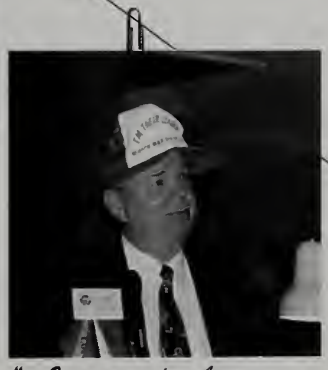


"The future looks bright, and we have a purpose...."





Dr. Jeremy Lazarus of Clear Creek Valley was elected to fill the remainder of the Alternate Delegate term of Dr. Joel Karlin...



"...I am proud to be your leader. Which way did everybody go?"

...who was elected to the new AMA Delegate's office. Dr. Karlin becomes Colorado's fourth delegate.





Dr. Painter congratulating Dr. Barbara Reed of Denver, the first woman AMA alternate delegate from Colorado.

HIGHLIGHTS OF BOARD OF DIRECTORS MEETING - March 7, 1997

Copic: Dr. Jerome Buckley, CEO, Copic. Copic continues to be a participant in the American Medical Accreditation Program (AMAP). Dr. Richert Quinn and Dr. Buckley have been appointed to sub-committees for AMAP. Dr. Buckley stated that they have hired a new CEO for Copic Agency. He gave a brief synopsis of the report he will give at the Saturday morning General Membership Meeting.

CMSA: Ms. Stella Shanks reported that the Alliance membership is at 780 members. She will be presenting a brief report at the Saturday morning General Membership meeting. They have collected $17,700 for the AMA/Educational Research Foundation (ERF). Their Legislative Day at the Capitol was very successful.

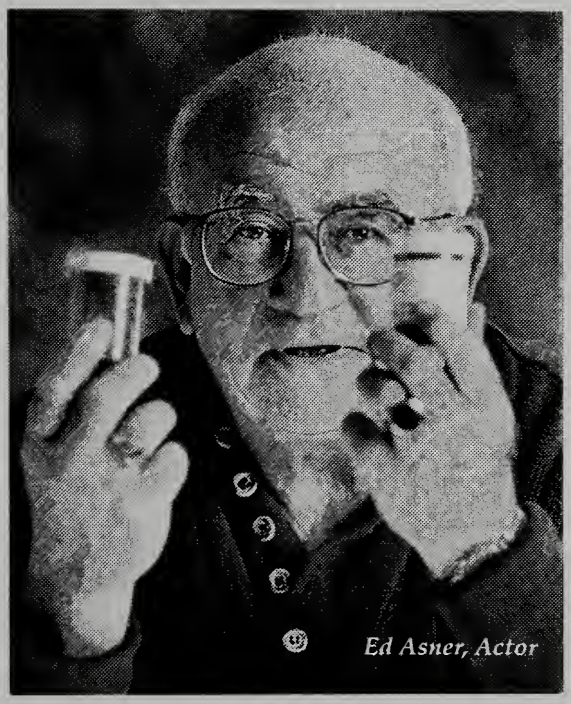
AMA Delegation: Dr. Ray Painter encouraged the members of the board to attend the AMA Open Forum on Saturday morning. CMS has increased membership in the AMA. As a result, we have been allotted a fourth delegate. The House of Delegates will be electing an AMA delegate, and either one or two alternate delegates, depending upon the outcome of the delegate race.

Colorado Physicians Network (CPN): Dr. David Martz stated that he will be presenting a CPN update at the Saturday General Membership Meeting. He stated that there have been some external impediments that have delayed the progress of CPN at the desired rate, but they have approximately 2,100 physicians enrolled. They have been attempting to broaden the primary care physician panel. The Medicaid Program has not been approved yet, because the Colorado Department of Health still needs to teach the local health departments the new program; and the Health Care Financing and Administration needs to approve the Medicare program. Medicare should be approved by sometime this fall

Colorado Rural Outreach Program (CROP): Dr. Jack Berry stated that the fund raising project has been very successful so far. CROP is going to hire a new fund raising consultant in the near future. Dr. Berry will be presenting at the General Membership meeting on Saturday. He thanked the Board of Directors for their support and donations.

President: Dr. Painter announced that the following physicians have agreed to be members of the Long Range Planning Committee; Dr. Barbara Reed, Chair, and Drs. John Farrington, Fred Grossman, Joel Karlin, Al Kortz, Muryl Laman, Louise McDonald, Ray Painter, Al Rapp, Gary VanderArk, Dave West and Hal Yocum.

Attention: Physicians



Have your patients' medicines had a check-up?

Many of your patients take several different medicines every day. Separately each one works well. But if they take two or more different medicines in combination without checking with you to be sure they work safely together, they can sometimes be harmful...even dangerous.

The next time you prescribe a medicine, ask your patients:

"What other prescription and nonprescription medicines are you taking?"

A public service message from the National Council on Patient Information and Education (NCPIE) and the U.S. Administration on Aging

Write for *free information* on patient medicine counseling.

OR FAX: (202)638-0773

Mail to:

NCPIE
666 Eleventh Street, NW
Suite 810
Washington, DC 20001

CopicComment

by Jerome M. Buckley, MD
Chairman & CEO
Copic Insurance Company



Review of Copic's Annual Meeting

Copic had its annual meeting the last weekend in February. At this meeting, we looked at our previous year and assessed our insureds' needs for 1997. Recalling the essence of our mission statement, we are to be needs-oriented while maintaining financial stability. Wehave met our financial stability requirements, finishing the year with ratios far superior tomost of our industry. Due to the success of our investments, we continue to operate the company without using a single premium dollar. Our annual report will provide furtherfinancial details for those interested.

As we reviewed the needs of individual insureds, they fell broadly into seven categories,which we will refer to as **"The Seven Rs":**

- Retention
- Retraining
- Retirement
- Retreading
- Retrenching
- Relocation
- Rehabilitation

Retention -- To meet your price-competitive needs, we must have as broad a base of insureds as possible. Therefore, retention is our #1 priority. As you have moved into group practices, become affiliated with hospitals, or developed ambulatory centers, we have designed programs to fit the needs created by these new environments.

Retrenching -- In response to the need for information on how to retrench, Copic is collaborating with Colorado Health Care Review to develop the Copic Practice Enhancement Series, a set ofno-cost audiotapes to be available in early 1997. The tapes explore current issues of concern to the health care community, combining lecture and panel discussion formats.

Retraining -- Copic and the Colorado Medical Society are funding a unique, in-depth seminar designed to help you examine your career and your options. "Leaving the Bedside - Yes or No?" will be held on June 6 in the auditorium of the General Classroom Building at the University of Denver. Details of meeting this need are published elsewhere in Colorado Medicine

Relocation -- During this past year, many of you asked if we knew of practice opportunities outside of the metro areas. To meet these needs, a unique recruitment program is taking shape. With support from the Copic Medical Foundation and USWest Foundation, the Colorado Rural Recruitment and Retention Network (CoRRN) is creating the Colorado Opportunities Bulletin (COB). The bulletin will be posted on the Internet under the Colorado Rural Health Center's web page at http:/ /www. aclin. org ./crhc.

Retirement -- Some of our insured physicians wanted to retire from active practice but continue to use their skills to provide volunteer medical care without exposing themselves to personal financial liability. Copic met this need in 1996 by making free professional liability coverage available for these physicians.

Rehabilitation -- Copic Insurance Company recognizes the potential vulnerability of our insured physicians to become impaired physicians. As we reviewed 1996, the need for assistance in this area was met by continuing our long-standing support of the Colorado Physician Health Program (CPHP).

Retreading -- In contrast, some physicians' needs are educational in nature. Copic meets these needs through our continuing support for the Colorado Physician Education Program (CPEP), which assesses physicians' educational and training needs and designs appropriate solutions.

During 1996, planning and negotiations took place to develop additional needs-based insurance products, especially long-term care and long-term disability. Further, to be sure Copic continues to be able to meet your needs in the 21st century, we are exploring strategic relationships with other Copic-type companies outside of Colorado. When I report to you on our 1997 annual meeting a year from now, we should have solutions and products for these long-term needs.

Don't let them Suffer In Silence!

Make every day count! Make this a day when, because of you, someone escapes the horrible clutches of domestic abuse and violence. Carry this calendar to help you remember that you can make a difference in your medical practice. See the other side for the resources available to your patients who may have a situation concerning domestic violence.

You can help your patients by directing them to the many resources in Colorado concerning domestic violence.
For May and June we are printing the list of domestic violence related resources that we know about.
The second half of the list will be printed in June.
For a complete list immediately, please contact Ellen Stein at the CMS.
We also have pocket size resource cards which you can make available to your patients.



John Lightburn, MD
Historian
Colorado Medical Society

The Colorado State Hospital

"But we believe it is safe to conclude that with our increased immigration, we can safely make calculation for an increased number of insane persons, and it is evidently the duty of the state to make preparations in advance for those who must inevitably fall under the care of the state."

Commissioner's Report
December, 1880

On August 1, 1876, the territory of Colorado was granted statehood by the U. S. Congress. As the governor, legislators and assorted politicians set about establishing the necessary infrastructure for the new state, towns and villages vied with each other to be chosen as the locale for the various state institutions and agencies. Denver became the capitol, Boulder received the state's university; Canon City the prison and Pueblo was given the Colorado State Insane Asylum. As an added inducement to the decision makers, Senator George H. Chilcott gave a 40 acre farm northwest of Pueblo as a site for the asylum. The legislature established a board of three commissioners to oversee the institution and they appointed P. R. Thombs, M.D., a former military man, the first superintendent. A small building accommodating 38 patients was built on the farm and it opened on October 23, 1879 with the admission of eleven patients on the first day.



The first Colodado State Insane Asylum, built in 1879.

The small asylum filled rapidly and prospective patients were often denied admission. In his first report to the Governor, Dr. Thombs wrote, *"During this report, there have been 77 patients admitted and 25 discharges. Of those, 23 have recovered and 2 improved to be ....cared for by friends; 2 escaped and 12 died: 2 died from phthisis within a month from their admission; 2 died from epilepsy; 4 from paralysis: one from typhoid and three from maniacal exhaustion. ....Of those dying of maniacal exhaustion, one died in a few hours and one in five days from date of admission. Had the local physician been consulted.... the patients would have been spared the journey to the asylum."* In this report, he predicted the need for a much larger facility and gave numbers supporting his contention that the state would save money if the legislature would provide for this anticipated need. He said it was unacceptable to keep patients in county jails while they waited for a bed to become available.

Also in this first report, he described the treatment provided for the patients in the asylum: "...in regard to the medical treatment of the insane, there are no specific remedies in use." After describing what was done to maintain the physical health of the patient, he continued "In addition to what may be accomplished by judicious medication, much may be gained by moral treatment.... consisting in efforts to overcome morbid impressions, diverting their attention from currents of thought and feeling that have been injurious, encouragement to engage in exercise, amusement and employment-- diversion being one of the most powerful remedies..... A great deal of work has been performed by the patients--the clearing of the land and fencing it,

(Continued)

the construction of ditches and sewerage, the planting of over 400 ornamental, shade and fruit trees has all been done by their labor... I find, aside from the benefits derived from their labor, a corresponding benefit to them. This is not a prison but a hospital designed for the care of disabled minds." After further extolling the virtues of labor and "moral therapy", he recommended several changes in the lunacy laws, that the law be changed so that "The sworn certificate of two physicians would decide the question of sanity or insanity, thereby saving the expense of trial by jury." A very enlightened thought for those times.

Thus did P.R. Thombs, M.D. start his tour as superintendent of the State Insane Asylum. He continued his efforts for twenty years, repeatedly asking the somewhat indifferent legislature for more funds for staff and buildings. During his tenure, the hospital grew to over 800 beds, the largest hospital in the state. He continued with the "moral treatment" with an overworked and too small staff. Nurses sometimes were forced to sleep on the wards because no housing was available. Toward the end of his tenure, he was charged with mismanagement and failure to visit the wards regularly. A hearing cleared him of the charges but he was nevertheless replaced by Dr. A .P. Busry.

A review of patient records during the first year gives us some idea of the state of psychiatry and medicine in 1879. The first patient was Moses W., a 43-year-old farmer from Arapahoe County admitted for epileptic insanity, who died after eleven months due to "convulsions". Joseph K., a 40-year-old peddler from Germany was admitted with acute dementia. He died six years later of dementia still in the hospital. Of the 77 admitted during the first year, 45 were given the diagnosis of mania: 8 had dementia; 5 melancholia; 9 had paralysis; 6 had epilepsy and 4 had idiocy. A 22 year old servant girl was sent to the hospital from Pueblo by the county judge with the diagnosis of nymphomania. The causes of these "insanities" were listed as intemperance in 10 cases, syphilis in 9 cases, masturbation in 4 cases and dysmenorrhea in 3 cases. The cause of other cases included head injury, meningitis, erysipelas, domestic trouble, religious excitement, nostalgia, destitution, seclusion, loss of property, old age and others. Life was hard for some of those early pioneers.



Colodado State Insane Asylum, circa 1888. Copy of an engraving printed in the Asylum's 1888 Biennial Report

A. P. Busry, the second superintendent, initially had as much difficulty as Thombs in getting money from the legislature, resulting in very meager care. But by the time he quit in 1913, there were 1,175 patients, convalescent wards were established and the staff was increased to include five physicians, one dietician and one part time dentist. Having provided more funding, the legislature then passed a law forcing the hospital to receive all cases committed by the courts, whether or not there was room.

In 1913, Dr. H. A. LaMoure became superintendent. In 1917, the legislature changed the asylum's name to the Colorado State Hospital. By 1923, the average daily census was up to 2,422. Beds were crowded into the wards less than two feet apart. That some people recovered and returned home is a tribute to the human spirit, the will to survive and to the dedication of an overburdened staff. Dr. LaMoure urged the legislature to establish another hospital in the northern part: of the state, but the Chamber of Commerce of Pueblo, fearing economic loss, successfully opposed such a move.

By the time Dr. F. H. Zimmerman became the fourth superintendent in 1928, the census had climbed to 2,800 and the hospital had become largely a custodial institution. Nevertheless, Zimmerman tried to introduce to the hospital the scientific advances in psychiatry and neurology to replace the "moral therapy" of Thombs' era. Zimmerman strived to bring the hospital into the 20th Century. Specific therapies were designed for schizophrenia, mania, depression, dementia and alcoholism. To accommodate the new patients and new therapies, 110 acres of land were added to the original 40 acres and the north campus was created. Zimmerman started a training school for psychiatric aides. Insulin coma therapy for schizophrenia and electric convulsive therapy were introduced. The Colorado Psychopathic Hospital was opened in Denver on the Medical School

campus for the treatment of the acutely ill patient. And yet the census relentlessly grew with more wards more crowded than ever.

Dramatic changes began to occur after World War II. In 1946, the National Mental Health Act established the National Institute of Mental Health and money became available for more personnel. In 1953 , chlorpromazine was introduced by Smith, Kline and French for the treatment of schizophrenia. And still the census grew. In 1953, the hospital still operated its own dairy and chicken farm, garden and piggery; some said the farm was more successful than the hospital. For 5,951 patients, there were five staff psychiatrists, two staff physicians, a chiropodist, two dentists, five psychologists and five social workers. In fiscal year 1959-60, there were 1,684 admissions and 913 discharges. There were 2,201 employes and the per-capita cost per day was $4.75. Total expenditures were $10,192,650.



The "Old Gray" building on the South Campus. the It was hospital's first Administration Building, built in 1883, demolished in 1968.

Dr. Zimmerman retired in 1961 after 33 years as superintendent. He must have been tired. Dr. Willis H. Bower, young and idealistic, the fifth superintendent, recruited more professional staff increasing the psychiatrists to seven and the social workers to 18. With Federal funds becoming available, new community mental health centers were established and a second state hospital, the Fort Logan Mental Health Center was opened to serve patients from the Denver area. In March of 1962, Dr. Bower with his new clinical director, Dr. Leanardo Earcia-Buneul, decentralized the care of over 6000 patients into 12 semi-autonomous divisions, eight to care for patients from specific geographic areas of the state and four to carry out special programs. This decentralization program won the American Psychiatric Association Silver Achievement Award in 1966.

Colorado State Hospital was no longer simply custodial. With more effective therapies, the census of the hospital began to decrease in spite of more admissions. Charles Meredith, M.D., became superintendent in 1963 as the census declined and specialized treatment programs for children and the mentally retarded were developed. By 1970, the census had dropped to 1300 patients, and the average length of stay for newly admitted patients was less than two months. As with all hospitals, the 1980s brought changes and complex demands for more adequate documentation, quality assurance and compliance with EPA (Environmental Protection Agency) regulations. Haydee Kort, M.D., the first woman superintendent, 1973 to 1990, presided over these changes with patience and fortitude. Hospital administration must have become more demanding and less fulfilling.

In 1991, the Colorado State Hospital was renamed the Colorado Mental Health Institute at Pueblo. As some services were discontinued and others decreased, new and innovative programs for youth and collaborative programs with the Department of Corrections have been developed. The inpatient census is now 530. Robert Hawkins, MSW, a forty year employee of the hospital was named superintendent in 1996 to become the first non-medical superintendent. Hawkins was originally employed as a food cart driver in the dietary department. What dramatic changes he has witnessed. He could tell his grandchildren a real story!

Editor's Note:

"'Zimm' was a great man."

Dr. Frank H. Zimmerman, Superintendent of the Colorado State Hospital for 33 years, served in that position longer than any other director of the hospital.

Born in Miles City, Mont., he attended grade schools in Dickinson, N.D. In 1911 he graduated from Howe Military School in Indiana. He received a doctor of medicine degree from the University of North Dakota in 1923, after which he joined the staff of the Colorado State Hospital in Pueblo. Two years later he was appointed director of the Mount Airy Sanitarium in Denver. About a year later he returned to the Colorado State Hospital as assistant superintendent, and was promoted to superintendent in 1928.

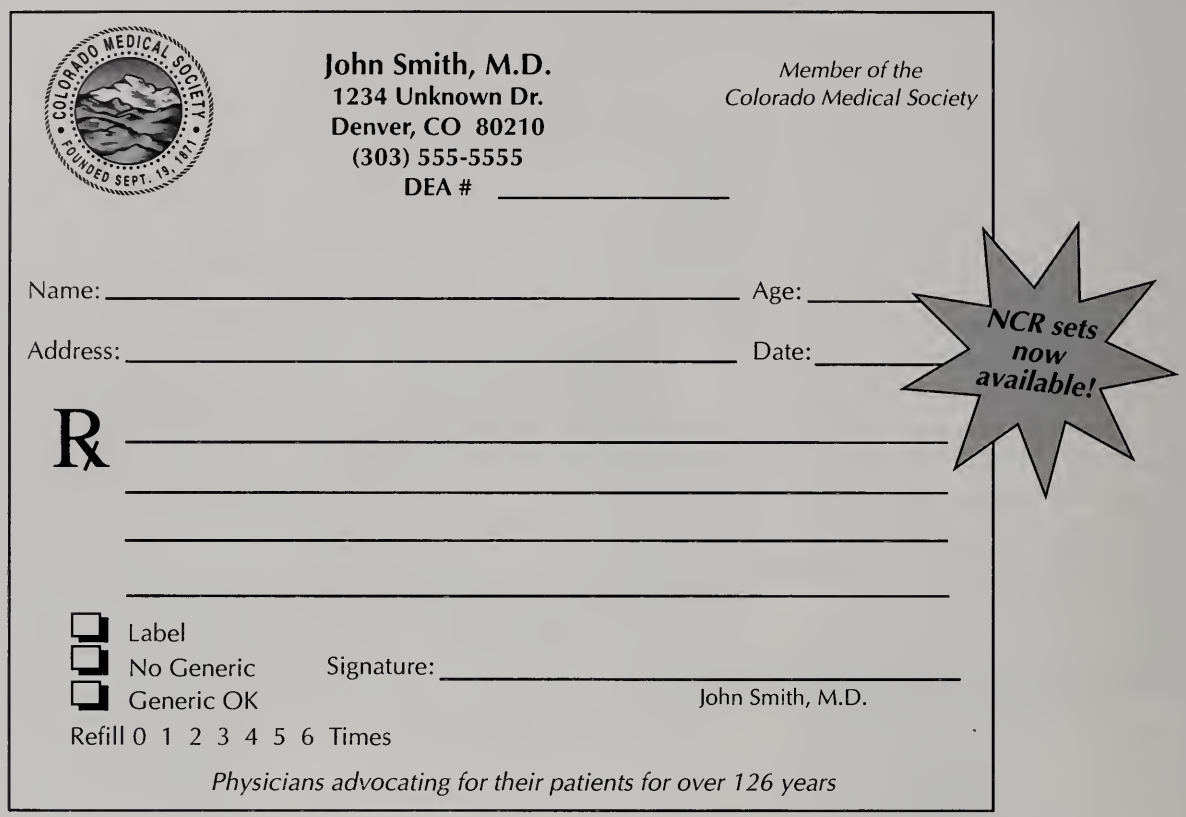
I came to know Dr. Zimmerman -- in one of my other lives -- during one of the many investigations of the Colorado State Hospital in the late 1950s. When I first met him at the hospital (in "Old Grey") he said "Just call me 'Zimm;' everyone else does".

I'm sure his military school training helped, but he set me straight on how anyone could handle the job of running that institution. "I do pretty well at the job," he said, "because in a place like this, it takes one to know one." I thought 'Zimm' was a great man. He died in Denver in 1979.

Bill Pierson

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Colorado Physician Network, Inc.



David C. Martz, MD
President
Colorado Physician Network

Time to Fish or Cut Bait

At the CMS Interim meeting March 8-9, we looked carefully at recent CPN developments, both in terms of delays and accomplishments, as well as impending actions.

We had hoped to be several months further ahead in our implementation at this point. Among the external impediments to our time line are HCFA's glacial processing of our Medicare application, Colorado Medicaid's delays in preparing communities to implement the new Managed Care options, and hospital officials who kept our contract proposals stuck in the "In" box on first one desk, and then another.

Meanwhile, we have augmented our PCP panel substantially in the Denver Metro area as well as in the northern Front Range. We have implemented our regional Medical Practice Review Committees all over the state and introduced them to the wonders of Peer-A-Med, our state of the art Utilization Review tool which provides education--rather than ejection--for our participating physicians. Likewise, 3 of our Disease State Management committees have completed their work, and a 4th is in preparation. We are intensely reviewing our marketing strategy before entering the challenging and competitive Denver Metro arena. Enrollment of participating members has indeed begun in the Northwest and the southern Front Range, and we are already paying claims to our providers for services rendered.

We will soon be sending you materials to place in your office to call your patients' attention to the unique benefits of Rocky Mountain Physicians Choice. Your own words to patients, colleagues, community contacts, clubs, and the press are essential to growth of enrollment--as proven consistently on the Western slope for over 20 years.

Yes, we are now prepared and poised to make it happen. 1997 is the year we must "Fish. . . . or cut bait"!

Don't let them Suffer In Silence!

For resource materials and patient information, contact: Ellen Stein at the CMS offices at 779-5455 or 1-800-654-5653 or E-mail *Ellen_Stein@cms.org*.
There are so many things you, the physician, can do to help people in distress and whose lives are actually endangered. Carry the calendar (included in this issue) to remind you and your associates of what needs to be done to save lives.
Don't hesitate a minute longer. Call us today!

Medicare Fraud and Abuse-
The Focused Medical Review

by Grant Steffen, M.D.,
Medicare Medical Director for Colorado

Part One of a Series

At the February 1997 meeting of the Colorado Medicare Carrier Advisory Committee, Grant Steffen, M.D., the Medicare Medical Director for Colorado, shared information on some of their upcoming "Fraud and Abuse" activities for this year. Physician members of the committee suggested that Dr. Steffen consider writing an article for Colorado Medicine *given the increased interest in this subject. Dr. Steffen agreed, and this article on "Focused Medical Review" is the first in a series on "Fraud and Abuse".*

Background

The Medicare Carriers have many tools for detecting fraud and abuse, one of these is the Focused Medical Review. Twice a year the Health Care Financing Administration (HCFA) provides the carriers with comparative data which identify possible irregularities in billings. Through the Focused Medical Review process, the carrier must research the procedure codes identified by HCFA and either (1) satisfactorily explain the reasons for the differences in local billing, or (2) determine that there is potential fraud and abuse involved and develop the individual cases accordingly.

– Marilyn Rissmiller, CMS
Department of Health Care Financing

Each year, HCFA supplies this carrier with data that show those services, supplies, and procedures that are aberrant, (i.e. those that are used significantly more than other providers of the same specialty across the country.) The chart below shows the twelve services and supplies that are at the top of the list for Colorado in 1996. The dollar figure represents the savings that would occur if the utilization had been at the national average. These numbers call to mind the quote: "There are lies, damn lies, and statistics!". The list obviously needs interpretation.

Perhaps the most striking elements are "Ambulance" and "Clinical Lab". The five ambulance aberrancies may not indicate inappropriate use of the ambulance trip but rather inappropriate billing of services given during the trip. In the second case, the physician has no control over this billing. But I would ask you to refer to the article in the *Medicare B News*, for March 1996, Issue #143, because it is critical for you, the physician, to order or approve ambulance service only when it is medically necessary.

The clinical lab aberrancies most likely have several explanations. I suspect that the Chem 22 and 80050 are ordered as screening tests. Therefore we have developed policies to stop payment on these two codes. Concerning the iron binding capacity, it may be that some clinical labs do that test whenever the hemoglobin or hematocrit is low, even though you did not order the test. Since the iron binding capacity test may not be at all necessary (you already know the cause of the anemia), I would consider this automatic test to be an abuse of the Medicare Trust Fund.

The two geriatric aberrancies are most interesting. CPT code 99311 is for the lowest level of subsequent

(Continued next page)

SPECIALTY	SERVICE	DOLLARS 'ABERRANT'
Ambulance	Advanced life support	$1,662,199.00
Psychologists	Psychiatric therapy, 45-50 min.	1,296,137.00
Clinical Lab	Chem 22 panel	426,166.00
Clinical Lab	80050, General health panel	266,949.00
Clinical Lab	83350, Iron binding capacity	187,205.00
Ambulance	Oxygen	183,953.00
Ambulance	Supplies, Advanced life support	181,175.00
Geriatrics	99311, Subsequent NH visit	144,887.00
Ambulance	IV Drugs	137,364.00
Geriatrics	99312, Subsequent NH visit	121,992.00
Ambulance	Routine supplies	116,491.00
Internal Medicine	Alpha 1 Proteinase Inhibitor	110,209.00

(Focused Review cont.)

nursing home care. Perhaps this is a "good" aberrancy. The geriatricians in Colorado are billing the lower level of care more often than the geriatricians in other parts of the country because they bill the higher level codes less often. However, note that the geriatricians were aberrant in their use of 99312, the middle level nursing home visit. Further down my list (not shown) is 99313, the top level. It shows a utilization slightly above the national average. The important observation here is that the geriatricians are not billing the lower level codes *in place of 99313*. They are billing all three codes more often than their colleagues in other states. What does this all mean? I do not know. Clearly, the carrier must focus on those physicians who are the most "aberrant".

The psychology aberrancy is not your issue, but it is clearly one that this carrier needs to evaluate. The alpha 1 proteinase inhibitor item is not an aberrancy, but can be explained, I think, by the fact that this drug is provided primarily by pulmonologists. We may have one or two internists in Colorado who do provide this drug. They would appear to be aberrant when compared to the other internists. Further refinement of the data should clarify this issue.

If you have any observations or questions on these data, please call me at (303) 894-5633 or write to Medicare B, 600 Grant Street, Denver, CO 80203.

If you would like a copy of the *Medicare Part B News* article mentioned above please call Marilyn Rissmiller at the CMS offices at 1-800-654-5653 or (303) 779-5455.

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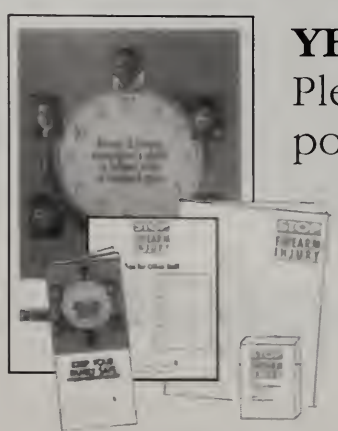
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Taking a stand:
Caring for Colorado's underserved

by Gary D. VanderArk, MD
President-elect Colorado Medical Society



Caring for Colorado's Underserved, the Colorado Medical Society's day-long conference on medical indigence, was a huge success. No universal solutions to the problems of the medically underserved were unveiled. In fact there was nothing new about the problems that were discussed. The conference was a success because it united a diverse number of health care professionals and renewed their communion, compassion and commitment to addressing the issues surrounding medical indigence (MI). An action plan was formulated (see page).to maintain access to medical indigent care and creatively respond to the effects of the changing health care system on the medically underserved.

To lead things off Annie Van Dusen, Senior Health Policy Analyst for the Colorado Department of Health Care Policy and Financing, and Barb Yondorf, Director of Policy and Research for the Colorado Division of Insurance, outlined the scope of the problem. Ms. Van Dusen's statistics showed the demographic distribution of Colorado's 550,000 uninsured population. Ms. Yondorf's then explained what is being done on the regulatory level to close the gaps in the provision of health care insurance.

In order to more fully understand the problem, Pete Leibig, Executive Director of Clinica Capesina, talked about the challenges facing MI providers. Dr. Ed Farrel, Medical Director of the Stout Street Clinic in Denver, intensified the audience's attention by giving anecdotal examples of what MI providers face every day. For the next hour, the conference analyzed private and public models of care which already exist. Some of the innovative programs that were discussed include the InnerCity Health Center of Denver, Doctors Care of Arapahoe County, Poudre Health Services of Ft. Collins, the North Colorado Family Residence Training Program of Greeley, the Marillac Clinic of Grand Junction and Community Health Centers of Colorado Springs.

Attendees then separated into four break-out sessions to discuss financing models, rural issues in indigent care/access, legal ramifications and administrative issues, and special populations. The participation in these break-outs was phenomenal. They would have undoubtedly continued if it were not time for lunch.

The fast pace of the conference didn't let up during the ensuing break. Dr. Marc Babitz, Associate Professor of Family Practice at the University of Utah Medical School, gave a provocative speech on the need for and effectiveness of community orientated primary care. Having spent seven and a half years working in community health centers all over Colorado, Dr. Babitz's comments and conclusions fell on receptive ears.

The stage had been set, the problem was identified and models

(Continued next page)

...a beautiful beginning.

(MI Forum continued)

of care had been explored. It was time to see how the coporatization of the current health care system was affecting MI care. To combat post pranial drowsiness, the "big dog" panel was introduced. Jeff Dorsey (President/CEO of Columbia HealthONE), Terry White (Executive Vice President of Centura Health), David West (Executive Director of Colorado Access), David Kikumoto (President/CEO Blue Cross/Blue Shield of Colorado), Dennis Brimhall (President/CEO of University Hospital) and Patty Gabow (CEO/Medical Director Denver Medical Center) made brief presentations and fielded a barrage of spirited questions from the audience. Access and financial support for MI programs were central issues of contention. Panelists and attendees noted the disproportionate amount of MI care provided by nonprofit hospitals and called attention to the need to keep health care dollars in communities instead of sending them out of state to Wallstreet.



From left, Jeff Dorsey explains Columbia HealthONE's policies as Terry White and David West search for answers of their own.

After a short break, the conference turned its attention to welfare reform and local and national legislative efforts. Colorado State Senator Sally Hopper reviewed current legislation. Michael Rothman, from the Department of Health Care Policy and Financing, discussed Colorado initiatives and Dr. Don Parsons came from Washington, D.C. to elaborate on national legislative efforts directed towards the year of the child.

More break-out sessions to develop action plans were then held. The four groups were chaired by outstanding facilitators including Carol Plock, Denise Denton, Peggy O'Keefe and Don Parsons. We applaud the work of each of these break-out groups.

Fusing all that had been learned and shared into an action plan for Colorado was left to Keith Moore from BBC who volunteered his services for the day. To his surprise the large audience was still both engaged and energized. Although it is difficult to get over two hundred people to agree on any strategy, there seemed to be consensus in many areas. Everyone agreed that the systemic nature of the problem requires cooperation and collaboration amongst health care providers, hospitals, third party payers, communities and state and federal agencies. Providers, legislators, the media, insurers, commerce and industry must work together to address access issues. Involving all of the elements of society, as was done in this forum, is critical.

No one at the conference was willing to sit back and wait for Uncle Sam to solve this problem. Caring for the medically underserved will occur on a community by community basis. Local resources must be mobilized to support essential providers. Conference participants also believed that there is enough capital currently in the system to effectively deal with the problem, however it needs to be redistributed to better serve MI needs.

Providers must continue to seek and implement innovative models for MI care. While the forum served to combat burnout which is epidemic among MI providers, health care professionals need not only share problems and successes. They must also seek to track MI care through benchmarking and improve continuity by making standardized forms and best practice guidelines. Medical informatics may be a great help in this regard.

In the end, the conference concluded with an awards ceremony and a riveting speech by Dr. Jack Lewin (see page 164). *Caring for Colorado's Underserved* was the first step in heightening Colorado's awareness about a problem which must be addressed by everyone. It also emphasized the distinction between comprehensive and incremental change. The problem of medical indigence is very old, and there are no easy solutions. However, forums where providers and others address the issue both comprehensively and incrementally are essential stepping stones to create solutions. It is in this way that the Colorado Medical Society can make a difference in caring for Colorado's medically underserved. This meeting was just a beautiful beginning. During my tenure as your leader, we will commit our resources to follow through on the action plan. A steering committee will be appointed to begin monthly meetings.



Dr. Don Parsons leads discussions in a break-out session.

A sincere thank you goes out to the Conference Planning Committee, Ellen Stein and the CMS staff, and Copic insurance for their support.

Medical Indigence: An Action Plan for Colorado

1) **Hold more medical indigence (MI) conferences** – Annual or even biannual meetings are needed to effectively address the issues and create policies. *Caring for Colorado's Underserved* was a good first step in raising awareness about medical indigence and creating a basic informational foundation about the issues surrounding the medically underserved. Future sessions should seek specific strategies to solve problems regarding access, funding and quality care. Moreover, participation should be increased to include the insurance industry, business and the press.

2) **Track policy** – Mechanisms to track policies and strategies should be implemented. Health care professionals who provide MI care must become more informed and aware of the actions that are being taken on their behalf to solve the problem of medical indigence. The more people know, the more they can effectively assist in creating a solution.

3) **Preserve Essential Community Providers (ECPs)** – Innovative models and financing structures must be created to maintain and preserve ECPs. These providers are critical elements in the provision of medical care to the underserved. Current third party payer policies threaten their existence.

4) **Align dollars with needs** – Seek strategies to redistribute money that is currently in the health care system to needy MI programs and providers. The current system provides fragmented, discontinuous care which relies heavily on disproportionate share hospital (DISH) payments for funding. More reliable means of funding must be sought.

5) **Raise Community Awareness and involvement** – Study and implement new communication programs to inform and educate the general public about solutions to the problems surrounding the medically underserved.

6) **Anticipate unintended consequences** – Increase communication and cooperation between all parties involved to avoid future problems which stem from present strategies. The current competition for Medicaid dollars demonstrates the unanticipated, negative effects that policies can have on essential MI programs. Steps must be taken to avoid future problems.

7) **Benchmarking** – Create more dialogue between MI providers to establish what practices work best to improve access, preserve continuity of care, track usage and bolster fund raising.

8) **Reinvest in communities** – Encourage managed care and other insurance companies to redirect portions of their revenues back to communities. Investment into the safety net should be tied to public health.

9) **Universal health care** – Seek legislative reform to provide universal access to quality care and level the playing field to enable more health care professionals to provide MI care.

The action points above are a collective representation of the conclusions reached by attendees of the Caring for Colorado's Underserved *Conference. They do not represent CMS policy.*

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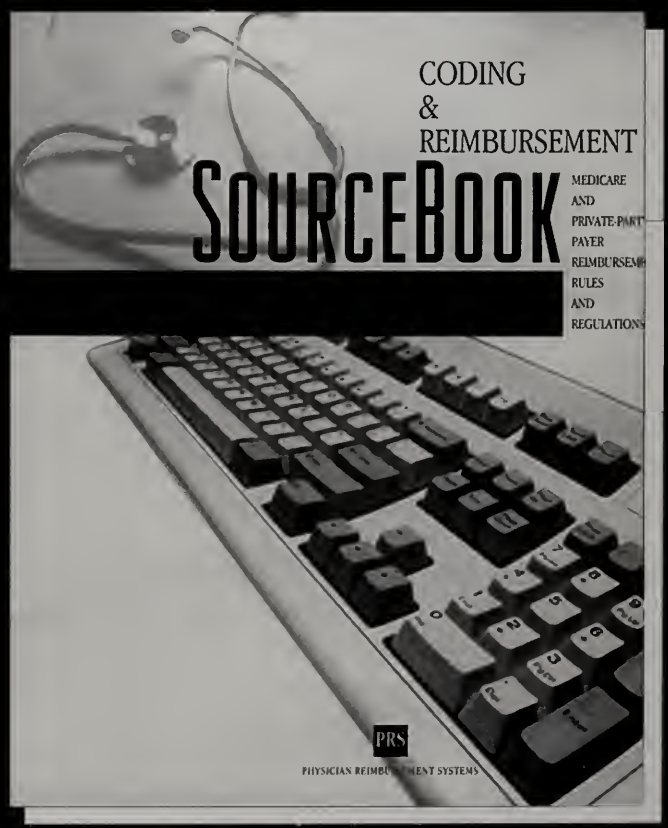
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Stout Street Run for the Homeless

by Shawna Harris Abbey, MSIV

The University of Colorado Health Sciences Center (UCHSC) Student Senate will host our fifth annual 5K walk/run for the Stout Street Clinic on Saturday, May 3, 1997 at City Park from 10:00 am to noon. The entry fee, which includes a T-shirt and post-run food and beverages, is $15/person pre-registration and $18/person on race day.

The Stout Street Run for the Homeless benefits the Stout Street Clinic, a medical facility that provides comprehensive healthcare to the homeless and economically disadvantaged populations in Denver. The clinic is one of the many services operated by the Colorado Coalition for the Homeless (CCH). Founded in 1983, CCH is a unique organization whose mission is "to work collaboratively toward the prevention and elimination of homelessness through education, advocacy, and improved services for the homeless".

The Stout Street Run for the Homeless affords the students of UCHSC the opportunity to raise funds to help support the mission and the clinic, in addition to providing a forum through which we can increase the awareness of the medical problems facing the homeless individuals and families in our community. UCHSC students have a year-round investment in the clinic. Every Saturday during the academic year, CU medical and pharmacy students volunteer as student doctors and pharmacists, thus ensuring that the Stout Street Clinic remains open for those clients who work and cannot make weekday appointments - a tremendous service, indeed! Many thanks to all of you who volunteer as attending physicians on those busy mornings.

Please share with us in making this year's Stout Street Run for the Homeless a tremendous success! Join us on race day to walk, run or simply enjoy a great time at City Park - bring your family and friends or just yourself -- we hope to see you there!

If you would like further information about the Stout Street Run for the Homeless or are interested in making a contribution to this effort, please contact Shawna Harris Abbey, UCHSC Student Senate Vice-President of Student Life at (303) 315-8254.

Resurgent professionalism

Highlights of the *Caring for Colorado's Underserved* keynote address



Dr. Lewin urged participants to engage patients to find creative solutions.

In his keynote address to the *Caring for Colorado's Medically Underserved* conference Jack Lewin, MD, Executive Vice President of the California Medical Association, succinctly summarized the problems of the uninsured. Using anecdotes and examples from his experiences in Hawaii and California, Dr. Lewin went beyond the statistics and theories to highlight the need for community involvement and physician leadership. This moving speech capped a day of discussion and renewed energy toward the provision of medical care to the medically underserved.

No stranger to the issue of medical indigence, Dr. Lewin was the Director of the Health Department of Hawaii for eight years. He played an instrumental role in initiating universal coverage in that state. Dr. Lewin's theme echoed many of the conclusions of the day. "The reason we haven't decided to make health care available to all Americans is because we lack the will to make it happen," he said. The current system with its employer based or single payer coverage has augmented the problem by "creating a system of haves and have nots".

Dr. Lewin noted the fragile nature of both Hawaii's employer mandated approach and California's market approach. To many the answer to medical indigence is always more taxes, more money and more government. He maintained that the solution cannot be found in the governmental equivalent of an 800 pound gorilla. Government involvement with the switch to a single payer system has not helped Hawaii. Conversely, employer mandated coverage is politically not feasible in California where the market has "ruthlessly" but effectively moved to control costs. Both examples demonstrate how fragile the process of reform can be at the state level. Reform on the national level is even more difficult because the federal government currently controls over 50 percent of the health care economy. This vested interest has negated the federal government's ability to be an unbiased referee to ensure a level playing field.

"The whole process is an unstable house of cards. There is no perfect model," he said. But there will undoubtedly be a massive adjustment once patients become aware of the cost shifting which will occur once the market driven system divests itself. Higher deductibles and co-payments, and heightened concerns about the quality of care will soon drive patients toward action and physicians must be ready to assist them. This is a time for a "resurgence of professionalism" in medicine because managed care is in its infancy. Dr. Lewin stressed the fact that physicians can and should take the lead and engage with patients to address issues surrounding the uninsured, access and quality. Communities and physicians must resolve to work with managed care companies to link their efforts back to the communities and patients.

In closing Dr. Lewin reiterated his beliefs that more government is not the answer, the market cannot do it alone, patients will play a larger role, and universal access must continue to be explored. The impetus for the conference was captured in his final remarks, "Nobody is in this environment without pain...It is not just a about economic necessity, it's about the integrity of medicine".

Liability Aspects of Drug Interaction Software
Part 2: Hazards



by Michael S. Victoroff, MD, Chair,
CMS Committee on Medical Informatics

Advances in Medical Informatics

Part 1 of this article (Colorado Medicine March 1997, vol. 94, Nr. 3) *advocated the widespread adoption of automated drug interaction checking (ADIC) software in ambulatory practices. The cost and risk benefits are compelling, and the liabilities are daunting if this readily available tool is neglected.*

But of course, as it becomes more widely employed, ADIC software, like any decision support tool, will reveal its drawbacks and shortcomings.

Shortcomings of Databases

Decision support software is only as good as the knowledge supporting it. Nationally, only a handful of companies generate the research for drug interaction databases. Among these are First Data Bank, Medispan and Micromedix. A few vendors do their own research (e.g. Multum), but most ADIC software freestanding or embedded in other programs licenses its information from one of these sources.

So, one factor in the adequacy of an ADIC system is the quality of its underlying research, and the editing of the knowledge base.

To avoid stalling on "trivial" interactions, many ADIC programs allow users to specify a "level of significance" below which the program will not report. Setting this adjustment is the responsibility of the clinician. But, determining the "level" at which an interaction will register requires an experienced research pharmacologist.

In addition to editing the knowledge base, software designers must make professional judgments about how to populate and maintain the database; and display the data in a useable way. To users of the program, these decisions are "transparent" (invisible).

Pitfalls of ADIC software occur in these general areas:

1. Incomplete or erroneous basic medical knowledge, or editorial misjudgements about how to prioritize or report it.
2. Software design errors that fail to capture correctly the knowledge stored in the database; or display it imperfectly.
3. Users' failures to understand the software operation or its limitations; or make proper use of its output.

Problems of Embedded Systems

There is a steady effort to develop systems which contain "embedded intelligence". Such software doesn't just issue warnings and advice, but takes autonomous actions based upon algorithms or "production rules". Dose calculation programs fall in this category.

Some decisions require "machine reflexes," for example, stabilizing high performance aircraft in supersonic maneuvers. But, when clinicians or fighter pilots, nuclear engineers, or submarine captains surrender executive authority to machines, they are dealing with a two-edged weapon. Accepting machine management means accepting machine error, a subject our culture has not adequately come to terms with, ethically or emotionally. (However, we seem to tolerate

"Accepting machine management means accepting machine error."

(Continued next page)

(Drug Interaction cont.)

machine error over human error, whatever that implies.)
Embedded systems have different regulatory, legal and ethical implications from systems that rely on "competent human intervention". These fall beyond the scope of this discussion.

Handout Hazards

Some products print "handouts" for patients, containing information about their prescriptions. These can be valuable, and most patients appreciate them.

However, when handouts contain inaccuracies, or address irrelevant issues, or poorly state concepts, they can interfere with therapy and create consternation on all sides.

When you license software that provides patient advice, make sure you know who's going to be liable for errors, omissions, obsolete data, statements open to interpretation, and content that offends someone. Manufacturers attempt to limit their liability, with disclaimers (on the screen or in documentation) like this: *"We have no clue where this information came from; it just showed up in our computers one day, so we started selling it. We have no idea how you will use it; we are totally blameless for anything you do. In fact, we advise you never to show it to anyone. If you do, any consequences are all your fault. Ha, ha."*

Some software forbids you to edit handouts. Either way, the manufacturer assumes you will carefully review and approve all content before giving anything to a patient. If you do tinker with handouts, be sure you know where you stand regarding copyrights of anything you distribute. You're on your own regarding malpractice liability, once you create an independent literary work.

Disclaimers can work for you, too. You can tell your patients, "I found this in the parking lot. I have no idea what it says." Perhaps better would be, "This is a pretty good handout. It's mostly true. But be sure to discuss any questions with me personally." Of course, if it's really bad advice, you're cooked regardless.

The Fallacy of Drug "Allergies"

You should inquire about adverse drug experiences (not just "allergies"!) from every patient at every visit including phone prescriptions. Any other practice is dangerous.

So called, "allergy stickers" represent a slovenly medical practice. Although a small number of adverse drug events are true "allergic reactions," the majority of toxicities and intolerances have nothing to do with IgE mediated immune reactions.

Drug Related Adverse Patient Experiences ("DRAPES") can occur at any time, even with medications that have been previously tolerated. Patients with persistent, chronic complaints, on chronic medications, should be scrutinized with the highest suspicion. The only way to assure timely information is to inquire at every visit. Even so, patients commonly forget, misremember, or presume "that information is in your files".

Well, it might be in your files somewhere. It's crucial to maintain a prominent and current (to the minute) list of DRAPES in every chart. Ideally, record all outcomes of all medications, whether adverse or favorable.

Systems that use the nomenclature, "drug allergies" are as obsolete as the diagnosis of "dropsy".

Overriding Alarms

Having interaction information means occasionally ignoring it. At some point, you've got to decide what data is insignificant. But occasionally, you may deliberately override a warning about a serious interaction. How do you inform patients about this? And how do you prove that you discussed the dangers of normal use?

Normally your warnings and instructions should appear in a progress note. But, for notorious drugs (like disulfiram, chronic

(Continued next page)

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The Colorado Physician Health program is a non-profit organization established by the Denver and Colorado Medical Societies. These physicians recognized that organized medicine had an important role in physician health: identifying and rehabilitating physically or emotionally distressed and impaired physicians.

(Drug Interaction cont.)

steroids or MAO inhibitors), you should ask patients to sign a note in the chart, acknowledging the hazards of both proper and improper use.

Storing Data

Some systems can store medication lists for patients who require repeated interaction checking. Will this take the place of information in your paper chart? If not, how will you maintain each? How will you avoid errors, when they don't match?

Computer stored records are vastly superior to paper ones. But "hybrid" systems (part paper, part electronic) present difficulties common to both.

Nuts and Bolts

The liability impact of even minor considerations can be substantial. Here are some final questions to keep in mind when shopping for ADIC software.

1. Where will the computer physically reside? (If it's not convenient, the software won't be used. It must be secure from unauthorized browsing and other abuse.)
2. How many seconds does it take to fire up the program and enter enough information for a useful report? (If it's slow, it won't be used. But incomplete information yields bad advice.)
3. Will you make printouts for the patient's chart? For the patient? Colleagues? (Patients must be informed of the nature and limitations of the data.)
4. Can the system ignore "trivial" interactions, and if so, at what level will you set it? (The bother of dealing with minor problems weighs against the cost of missing major ones.)
5. Will you delegate the task of interaction checking? Who in your office is qualified to modify prescriptions or discuss hazards with patients? (It may not be wise to economize on this task, since clinical judgment is required at several stages in the process.)

Your office procedures should assure that you can identify significant interactions for every patient for whom you write or refill a prescription. ADIC software is an indispensable tool for this end, and an emerging clinical standard. It is vulnerable to errors of omission and misinterpretation. But it should be one of the first utilities contemplated by any physician in the market for computer decision support.



Rx Software Resource Directory

The following is a list of drug interaction software vendors. It is in no way a complete representation of all available vendors. Nor does this list represent an endorsement for any of these products by CMS. It is strictly intended as a resource.

"Drug Interaction Facts on Disk"
Facts and Comparisons
St. Louis, MO
800-223-0554

"Drug Master Plus"
Rapha Group Software
St. Louis, MO
314-521-0808

"Drug Reax"
Micromedix, Denver, CO,
(303) 486-4740

"Drug Therapy Screening System"
Medispan,
Indianapolis, IN
800-428-4495

"Medical Letter Drug Interaction Program"
The Medical Letter
New Rochelle, NY
800-211-2769

"PDR Drug Interactions"
Medical Economics
Montvale, NJ
800-232-7379

"Physicians GenRx"
Mosby-Year Book
St. Louis, MO
800-426-4545

"S-O-A-P Rx"
Patient Medical Records, Inc.
Brownfield, TX
800-285-7627

"Drug Information"
First Data Bank
San Bernadino, CA
800-633-3453

"Medisource"
Multum Information Services, Inc.
Denver, CO
(303) 733-4447

Alliance Day at the Capitol

Building grassroots support for medicine



From left, CMSA members Patti Brown and Lynn Painter discuss the issues with Rep. Larry Schwarz.



Chuck Berry, Speaker of the House gave a legislative update.

Each year support for organized medicine grows at the Colorado State Capitol. Sometimes it is a long and arduous process. However, grassroots action, like the Colorado Medical Society Alliance's "Day at the Capitol," is the essential foundation upon which future legislative relations can be built.

As in years past, the event was a success. Over 30 Alliance members attended in addition to a number of CMS members. The format was changed a little from previous years to incorporate a continental breakfast outside the Old Supreme Court Chambers. So many legislators attended that more food had to be ordered! Rosalie Schreiber, Metro Denver, did an excellent job of organizing the activities of the day.

Following breakfast, attendees were briefed on current legislative activity by CMS lobbyist Jerry Johnson and Lorraine Koehn, Director CMS Government Relations Department. House Speaker Chuck Berry outlined how current welfare reform legislation may affect health care. He was quick to note his concerns about the need for continued quality care. Rep. Mary Ellen Epps echoed his theme by arguing for increased legislative vigilance to prevent managed care from subverting that priority. Other speakers included Sen. Sally Hopper, Rep. Martha Kreutz, Rep. Peggy Reeves and CMSA member Rep. Joyce Lawrence.

The new format along with continued, strong support guarantee that next year's "Day at the Capitol" will be even better. CMSA would like to thank everyone who participated. Grass roots action can make a difference.



Rep. Mary Ellen Epps encouraged attendees to work with their legislators to educate them about the current health care system.

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ASPEN: Well established internal medicine practice seeking **Internist-Gastroenterologist** to join three physician practice. Please fax C.V. to 970-920-2282 or call Christine at 970-925-5440 M-F, 9-5. 03/0497

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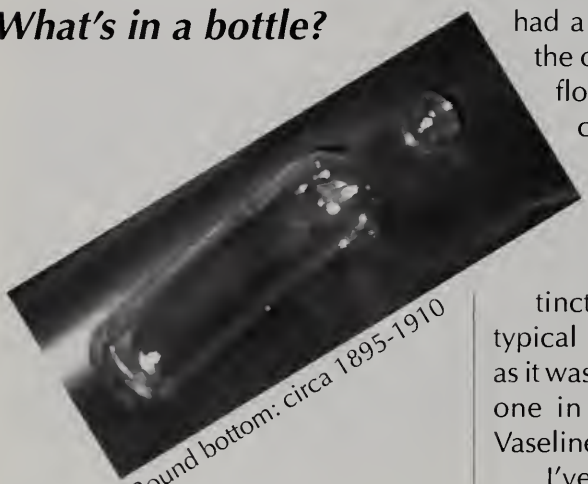
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For additional resource materials, contact Ellen Stein at the CMS offices. 779-5455 or 1-800-654-5653 or E-mail *Ellen_Stein@cms.org.*

RUMINATIONS

(**def:** chewing again what has been chewed slightly and swallowed; to **REFLECT**)

*by **Bill Pierson**, Managing Editor*

What's in a bottle?



Round bottom: circa 1895-1910

What was in a bottle? Especially one that's 75 to 100 years old? It isn't the bottle's contents; it's what the bottle did when it was functioning, circulating, etc. And the Antique Bottle Club of Colorado is a group of dedicated collectors who relish the history that a bottle brings to life. This is particularly true (and colorful) when it comes to medicines or "cures" of the turn-of-the-century period. These medicines were called "proprietary" or "Patent" medicines.

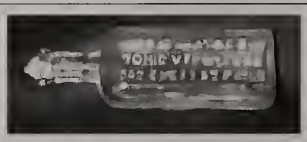
Early Denver was a colorful place, probably as colorful as anywhere in the Frontier West. There are many old rubbish dumps, abandoned outhouses, places where bottles are likely to hide. It's fun to run across a bottle that bears the name of "Frank Marshall, Chemist. Denver, Colorado". That was one of Denver's leading pharmacies between 1850 and 1910. He bottled his own patent medicine.

Bottles have distinguishable personalities. Patent medicine containers stood out from other containers. They had a certain flair to the neck, and the opening was small, to limit the flow to large drops, making the contents more guarded and available in small quantities. Ointments and other applications, such as iodine, mineral oils, etc., were always distinctive bottles. Interestingly, the typical vaseline jar of today is much as it was in the 1880s. The short, stocky one in the photo is a "Cheesboro Vaseline" jar.

I've been watching a bottle "dig" in old Denver over recent weeks, and it's genuinely exciting when a digger comes up out of his hole with a shout, holding a bottle or a jug that is particularly scarce and sought after... **and** unbroken. These diggers are hobbyists, and they do exchanges and sales among themselves because they all pursue certain types of containers. Probably the most popular are whiskey bottles. They are a real-life reminder of those passed across the saloon bar to the likes of film actor John Wayne or the real "Billy The Kid".



Patent medicine bottles circa 1900



DR. D. JAYNE'S TONIC VERMIFUGE 242 CHESSIE ST. PHILA.



Quart bottle (right) Labeled: "BUFFALO LITHIA WATER NATURES MATERIA MEDICA"

The round-bottomed bottle pictured here had a limited purpose. The bottle didn't care what it bore, but its design caused the bottle to lie on its side, thereby keeping the fluid contents against the cork. This kept the cork damp. If the cork dried, the soda or seltzer water would blow the cork out of the bottle. This bottle was used in Denver around the 1900s for soda pop. Another bottle that turns up frequently hereabouts is the "Buffalo Lithia Water" bottle, labeled "Natures Materia Medica". It was bottled in Cincinnati, OH.

It's great for the diggers to find "Denver glass", containers actually made right here in Denver, Colorado. A few bottles have been found over the years bearing the mark "CT" standing for "Colorado Territory". These were obviously made and used some time before 1876.

If you are interested in participating in antique bottle collecting, write the Antique Bottle Club of Colorado, P.O.Box 245, Littleton, CO 80166.

COLORADO MEDICINE

"Advocating excellence in the profession of medicine"

, 1997

Volume 94, Number 5

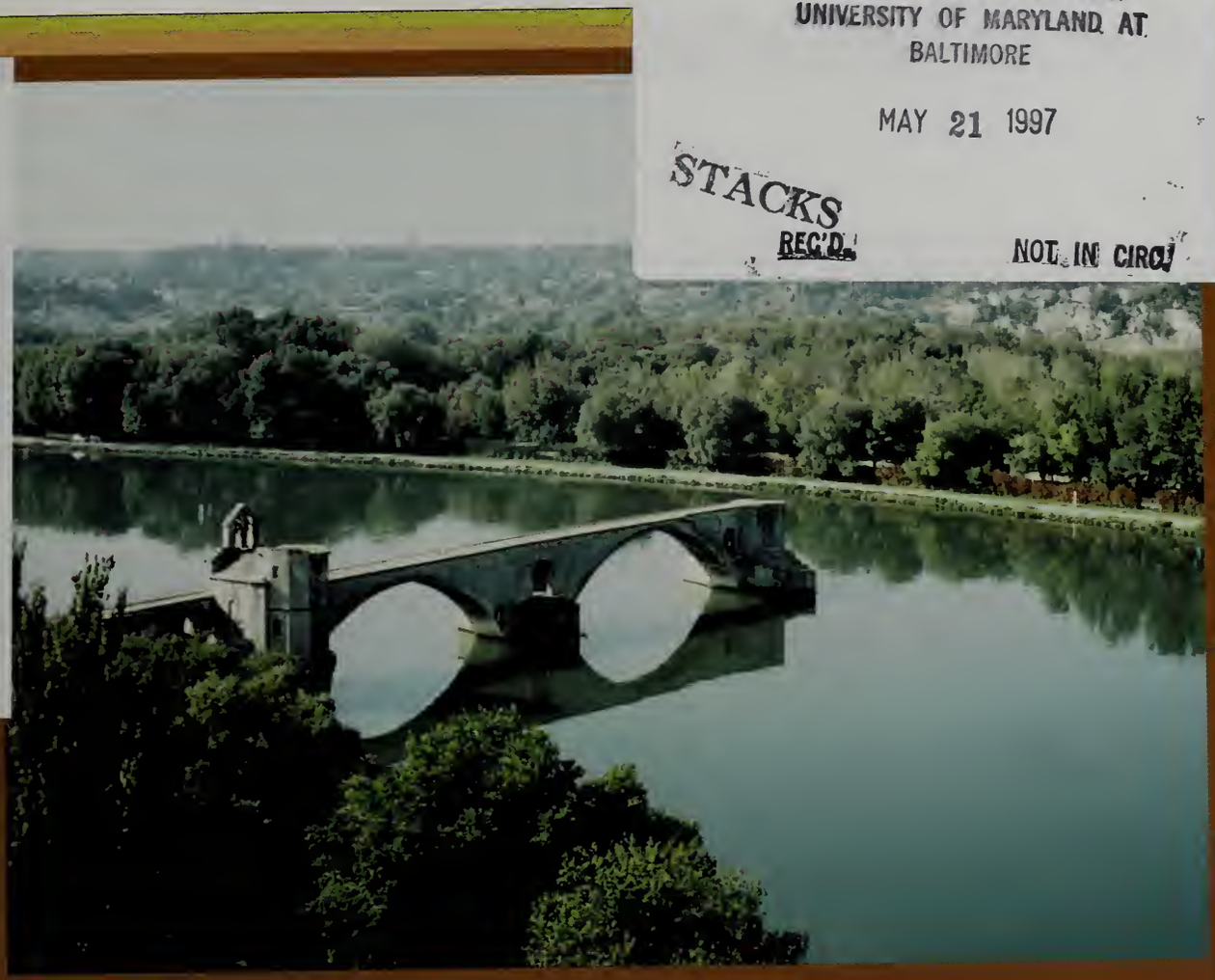
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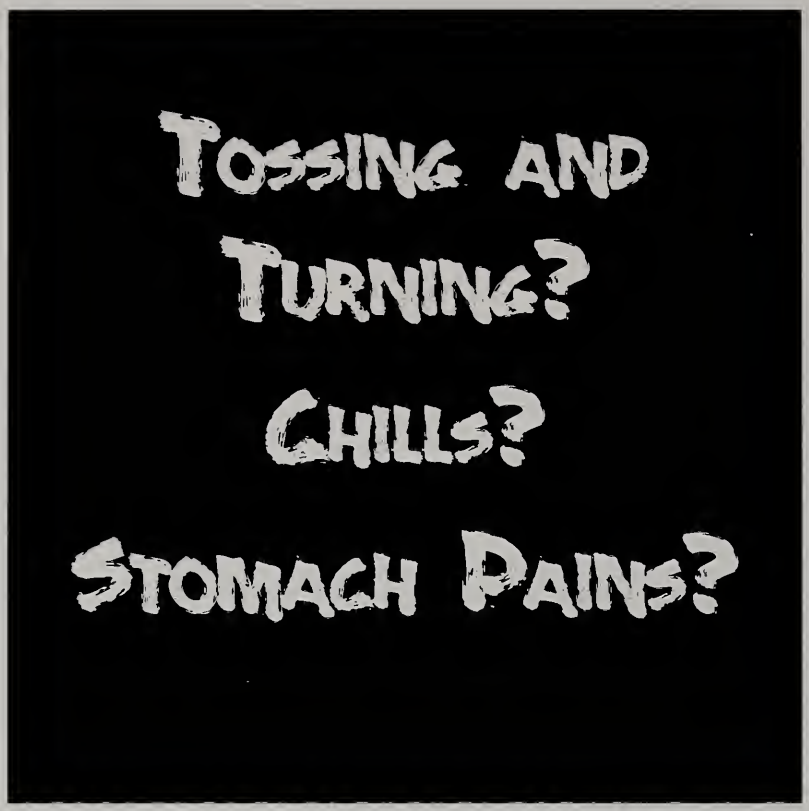


A bridge not quite far enough... but after years of separation, clinical and academic physicians are drawing closer together. Lines between the traditional "Town" and "Gown" medicine become more and more blurred as "Contract Medicine" grows. **Donald Eckhoff, MD,** CMS Board member describes "Academic doctors: who are they and why are they competing?" and former CMS President **John Sbarbaro, MD,** speaks of "Competition Revisited."

(Starting on page 194)

This Issue:

Contract Medicine by M. Ray Painter, MD ..... page 177
Measurable Outcomes at CU by Richard Krugman, MD, Dean, School of Medicine..... page 188
CMS Leadership Conference-Schedule/registration ..... page 191
A living legend/A multiple legacy by John L. Lightburn, MD, Historian ..... page 206



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May, 1997 Volume 94, Number 5



Cover Story

Where's that confounded bridge? The comparisons between academic and clinical physicians are closer than you may think. Can the gap between the two be crossed? See pages 194-197.

Departments

177 President's Letter
179 Executive Director's Update
183 The Lobby
195 Colorado Physician Network
200 Copic Comment
201 Letters to the Editor
203 Member Services
204 Health Care Financing
206 Archives
210 Medical News
212 Classifieds
214 Ruminations

In This Issue...

177 **Contract medicine** - third party payers fall into three categories – "the good, the bad and the ugly." Here is what you need to know to prevent delayed payments.
M. Ray Painter, MD
President, Colorado Medical Society

186 **Domestic violence** - mountain communities respond to help physicians deal with this problem in their practices.

188 **CU School of Medicine** - new initiatives in the Primary Care Curriculum are starting to reap big benefits for students, mentors and preceptors.
Richard D. Krugman, MD, Dean,
University of Colorado School of Medicine

198 **Cloning Joe** - a physician's reflections on how the tobacco industry continues to flaunt its lack of concern for public health.
Thomas H. Coleman, MD

204 **Medicare fraud and abuse** - a quick primer on HCFA definitions and how to avoid becoming a textbook case.
Grant Steffen, MD,
Medicare Medical Director for Colorado

206 **The life and times of Henry Sewel, MD** - a venerable icon of medicine in Colorado whose impact is still being felt today.
John L. Lightburn, MD, Historian,
Colorado Medical Society

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Sandra L. Maloney, Executive Editor; William S. Pierson, Managing Editor; Chet Seward, Administrative Asst.

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M. Ray Painter, MD
President, 1996-1997

CONTRACT MEDICINE: The good, the bad and the ugly

This year I have covered many topics in my column - some factual, others related to "opinion." Contract medicine and the variable payment policies of third party payers is a subject which I have spent years studying and have therefore developed a reasonable understanding and considerable expertise.

This article pertains to third party payers, how you are paid, and more importantly, why you are not paid for services rendered. We are in the habit of judging a payer by the conversion factor that we've been able to negotiate. In reality, that is only the beginning. When you have negotiated your reduced fee, don't give a sigh of relief. Your efforts now entail careful scrutiny of the payment rules as outlined in your contract, and are available to you from the payer. The lack of knowledge of specific payer rules and understanding of the system may be costing you thousands of dollars per year.

Payers fall into "the good, the bad, and the ugly" categories. The "good" are those who have attempted to learn the coding system, with its accompanying reimbursement methodology, and work hard to be fair in paying physicians what they deserve for services rendered. Those in the "bad" category are unfair or inaccurate in their practices - either because they have not learned the system or because they know the rules but are very careless and/or inconsistent in the ways they apply them. In the "ugly" category are those who know the rules but have developed the payment methodology in order to keep as much of your money as they can. They're the ones who take advantage of the offices that have not bothered to learn the coding system, have not read the contract(s), do not know the rules by which they're being paid, and do not track payments to be sure the insurance company is paying according to its rules. I've seen instances in which insurance companies were keeping over half of the compensation that an office should have been paid based on that specific contract.

Identifying the category of the payer with whom you are dealing and then work with them accordingly.

Listed below are some specific areas to pay particular attention to in filing claims for services rendered.

- **Billing and payment timetables.** Note carefully the claims filing requirements and payment time frames.

Be aware of delayed payments, unreasonable requests for additional information/documentation and particularly lost claims. Denied claims should be investigated thoroughly!

- **Levels of E & M coding.** You're probably well aware that some managed care companies only pay one level regardless of the amount of work done.
- **Global periods.** Global periods vary considerably from St. Anthony/McGraw-Hill to Medicare, and may change with different payers.
- **Bundling** Bundling varies significantly from payer to payer.
- **Supplies.** This is a big money loser! The CPT codes do not incorporate supplies nor do the relative values that were developed. Therefore, all special supplies should be charged separately. However, remember that Medicare included supplies in their E & M payment. Some payers do and some do not.
- **Multiple procedural reductions** may vary from one payer to another.
- **Modifiers.** Remember that some insurance companies do not use modifiers in their payment system.

"The lack of knowledge .... and understanding of the system may be costing you thousands of dollars per year."

Be educated, be diligent and beware! There are denials in the futures of those who are not.

CMS is currently attempting to gather specific collection problems from our members. These details will become a part of an ongoing data base. We want to know about your specific payment problems. If we do know, there is a much better likelihood that CMS can help you in these areas.

Also, CMS can help with questions about these and other areas now. We have coding and payment experts on our staff. Call Marilyn Rissmiller in the Health Care Finance office of CMS at 930-0428 or 1-800-654-5653, extension 2428.

LEGAL UPDATE

from Gelt, Fleishman & Sterling P.C.



A. Craig Fleishman, Managing Director

Entities and the Attorney Client Privilege

Part II

The "Control Group Test: was first articulated in a case in which the plaintiff sought to discover statements made by non-managerial employees of a corporation to the corporation's counsel during the attorney's investigation of a lawsuit. Here, the court determined that a communication was protected by the attorney client privilege only if the employees participating in the conversation held a position within the corporation which allowed them to control the corporation's ability to follow the attorney's advice. Communications between the corporations attorney and those persons in non-managerial positions within the corporation were not protected.

The "Control Group Test" may have created as many problems as it solved. This theory failed to consider the role played by middle- and lower-level employees in implementing the decisions made by the "control group." Even though corporate or association counsel will often find it necessary to speak with employees who fall outside of the control group in order to obtain the information necessary to render legal advice, these communications were not protected by the attorney-client privilege.

As a result of this and other problems, many courts have adopted the "Subject Matter Test" for determining when the attorney client privilege applies in association or entity contexts. A communication will be protected by the privilege under the "Subject Matter Test" if all of the following are true: (1) the communication would not have been made but for the contemplation of legal services; (2) the employee made the communication at the direction of his corporate superior; (3) the superior made the request of the employee as part of the corporation's effort to obtain legal advice; (4) the subject of the communication involves the legal services being provided; (5) the subject of the communication is within the scope of the employee's duties; and (6) the communication is disclosed to others in the corporation only on a need-to-know basis.

The "Subject Matter Test" more fairly addresses the very real problems presented in associations or corporations by recognizing that association or corporate counsel will often find it necessary to discuss legal questions with non-managerial employees.

The attorney-client privilege protects corporations and other entities by allowing open and honest discussions with counsel when obtaining legal services. The privilege can also be a trap for the unwary when statements are made which must later be disclosed to one's legal adversaries. Whenever an entity is facing a legal challenge, it is important to involve counsel early on in the process so that steps can be taken to assure that the appropriate information is obtained in a timely manner and in a way that will prevent the subsequent disclosure of confidential information.

For further information contact:
Gelt, Fleishman & Sterling P.C.
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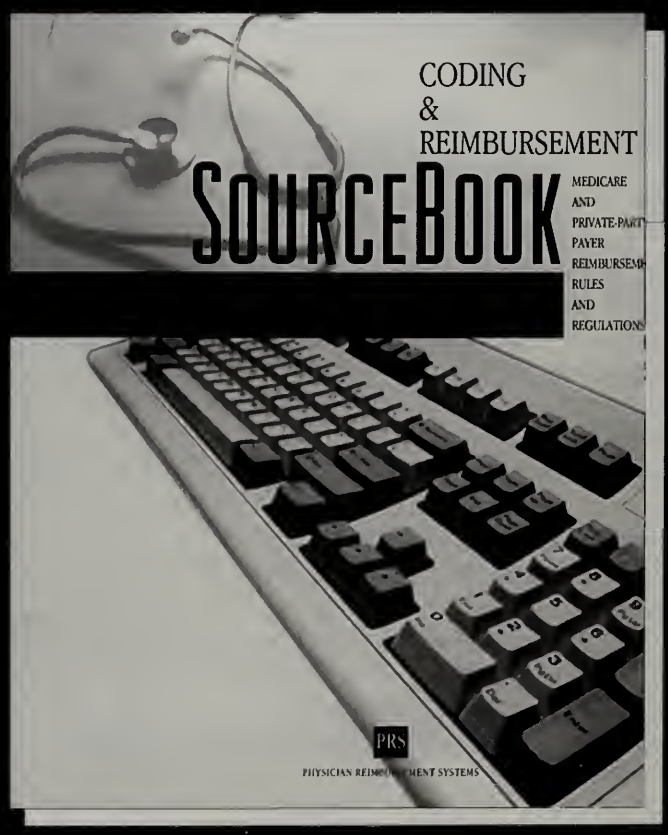
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For more information, call Marilyn Rissmiller in the CMS Health Care Finance Department at 779-5455 or 1-800-654-5653.



CMS Med Fax®

...a compilation of medically-related news briefs of immediate interest to the physician community occurring after ***COLORADO MEDICINE*** has gone to press. ***AT PRESS TIME...***

CMS Med Fax®
by Montgomery Little and McGrew, P.C.
legal counsel to the Colorado Medical Society

CMS opposes Medicare Competitive Pricing Demonstration Project

Since this project was last discussed in the March 1997 issue of *Colorado Medicine,* CMS leadership and staff have been monitoring developments. Although the Health Care Financing Administration's (HCFA) overall goals for this project may have been commendable, it now appears that some of the "fallout" will be less desirable.

- The standardized benefit package required for bidding purposes will result in a change in benefits for most Medicare beneficiaries enrolled in an HMO (one example is, prescription drugs reduced to a maximum of $1,000 per calendar year).
- The bidding process itself could easily result in additional costs to the beneficiaries in the form of premiums.
- The demonstration project will penalize Colorado by taking money out of our economy (e.g., a five percent reduction in the government's contribution for the more than 80,000 Medicare HMO enrollees would cost Colorado $22,800,000 in the first year alone).
- The government's reduction would in all likelihood be passed on to all health care providers, including physicians.

For these reasons your CMS leadership, with the concurrence of the CMS Board of Directors, has gone on record in opposition of this project. We have advised HCFA and our Colorado Legislative Delegation of our concerns. Activities are currently under way at the state and national levels to kill this project. CMS will advise you of the outcome.

NDMA calls for physician help in flood relief

The North Dakota Medical Association (NDMA) announced a state-wide effort to provide physician relief services to assist in the early reconstruction effort in Grand Forks.

Robert Grossman, M.D., President of the Association explained the program. "When the residents of Grand Forks and other communities along the Red River are allowed to return to their homes, we must be prepared to provide necessary medical care. Most local physicians will be returning to damaged homes, and will certainly want to assist their families and friends in the clean-up effort. We are asking other physicians across the state to help out during this most difficult transition period by providing their on-site medical expertise."

Physicians in any specialty wishing to volunteer their services during the upcoming weeks of restoration are asked to call 701-223-9475 or 1-800-732-9477 to register with the Association. All services, regardless of duration, would be greatly appreciated.

Cathy Rydell, Executive Director of the Association has contacted other State Medical Associations requesting out-of-state physician volunteers to assist in the effort as well. "The response has been very gratifying. We are confident we will be able to help staff the medical facilities with fully qualified physicians."

Once local authorities have approved the return of Grand Forks residents to their homes, the North Dakota Medical Association will coordinate the physician relief effort with the local medical community. Volunteers on the roster will be contacted to arrange specific times and locations for providing support and care to citizens in the Grand Forks area.

Dr. Casey Ryan, President of the ALTRU Health Systems (United Hospital-Grand Forks Clinic) expressed his gratitude. "We are so thankful for the compassion and generosity of our fellow physicians. Together we will assure the health care needs of the people of the region will continue to be met during these difficult times."



Med Fax: Medico-Legal News

by Karen B. Best, Esq., an associate with the law firm of Montgomery Little & McGrew, P.C.

This column contains information concerning topics of general interest in the medical-legal field. For further information or help with specific problems, please contact Montgomery Little & McGrew, P.C.

Gag Clauses in Physician Contracts

A recent front-page article in the Rocky Mountain News (March 24, 1997) alerted readers to a problem physicians are all too familiar with. The headline read: "Doctors face 'gag' order" —"'Gag' order sparks uproar." This particular article referred to a confidentiality agreement sent to a group of Colorado health care providers for a large managed care plan, in anticipation of the group's annual meeting. The confidentiality agreement referred to broad categories of information which would be discussed at the annual meeting and which, under the confidentiality agreement, could not be disclosed by member physicians to any third parties. Some alert physicians receiving the agreement recognized the potential problems inherent in the agreement, and the so-called "uproar" followed.

This space is too limited to offer even a fair summary of the controversy surrounding "gag clauses." I can only attempt to skim the surface. So fundamental and far-reaching is the debate that part of that debate even includes the extent to which, and whether physician contracts contain gag clauses. In the past, some proponents of managed care have argued that these provisions are not commonplace and therefore not a problem, while physician and patient/consumer advocates have perceived their use as widespread and problematic.

"Gag clauses" limit communication between physicians and their patients by implicitly or explicitly prohibiting the disclosure of certain information; for example, 1) discussion of treatment options with a patient unless the plan has authorized payment for the treatment; 2) making critical comments about the plan, its policies, or quality standards to enrollees or other physicians; 3) communicating with plan patients in the event the physician is deselected (which could raise concerns about continuity of patient care); 4) discussing plan financial incentives to reduce care, including capitation and utilization review protocols; and 5) referring patients to other specialists or facilities not participating in the plan.

Managed care plans argue in part that these limitations on communication are designed for legitimate business purposes such as containing costs and protecting proprietary information in a fiercely competitive market. Others argue that they are designed to control physician behavior and limit patient access to the full range of information needed by patients to make informed decisions and to provide truly informed consent for their own care.

The AMA which fervently opposes gag clauses argues that gag clauses cut to the heart of the physician-patient relationship by undermining trust, and that they impede the ethical duties of physicians to act, above all else, as patient advocates. The AMA argues that they prevent physicians from giving patients information about treatment options that may not be covered by their health plans, even if these treatments are safe, effective and necessary. They may also prevent physicians from referring very sick patients outside their health plans to physicians with rare expertise in the types of care needed.

The AMA Council on Ethical and Judicial Affairs has declared gag clauses "an unethical interference in the physician-patient relationship, " and in January 1996 released the following statement on gag clauses: "The physician's obligation to disclose treatment alternatives to patients is not altered by any limitations in the coverage provided by the patient's managed care plan. Patients cannot be subject to making decisions with inadequate information. That would be an absolute violation of the informed consent requirements. If these clauses are carried out and the physicians are subject to sanction, a reduction in the quality of patient care will result." The statement follows a 1994 report, "Ethical Issues in Managed Care," outlining in detail the ethical duties of physicians practicing in managed care settings.

The AMA has invited managed care organizations to submit their contracts for review to determine if they interfere with the physician-patient relationship. It also has called upon all physicians to continue to abide by their duty to provide patients with all relevant information regarding treatment alternatives, regardless of the provisions or limitations of health plans. Significantly, it has also offered to "stand behind any physician who believes he or she is prevented from fulfilling the ethical duties due to a gag clause or similar policy."

The fact is "gag clauses" are found in enough physician contracts to induce about half the states, including Colorado, to enact anti-gag clause and anti-retaliation legislation. Colorado's statute, enacted in 1996, requires all contracts between health carriers and

(Continued next page)

(Gag clauses continued)

health care providers to include provisions stating that 1) providers shall not be prohibited from protesting or expressing disagreement with the practices of the carrier; and 2) the carrier shall not terminate the contract of a provider because the provider expresses disagreement with a carrier's decision to deny or limit benefits, because the provider assists the covered person to seek reconsideration of the carrier's decision, or because a provider discusses with a current, former, or prospective patient any aspect of the patient's medical condition, any proposed treatments or treatment alternatives, whether covered by the plan or not, policy provisions of a plan, or a provider's personal recommendation regarding selection of a health plan based on the provider's personal knowledge of the health needs of such patients. C.R.S. S 10-16-121. Clearly, the statute protects physicians who discuss treatment options with patients, even if those treatment options are not covered by the plan. It also indirectly protects the patient's right to know.

However, the question ripe for litigation is whether physicians are protected from termination or "deselection" if they disclose financial information concerning the plan, such as financial incentives. Our statute does not explicitly address financial information. And because the statute has not been tested or interpreted by the courts, we do not know whether the statute provides any protection from the carrier for the disclosure of financial information concerning a plan. Inevitably, the argument will be made that physicians have a legal and ethical obligation to disclose any information that would be significant to the patient in making an informed choice about his or her own care, and that any contract which abridges that duty is illegal, against public policy, and unenforceable.

Courts are finding that patients have a right to know when a physician has a financial stake in making or not making a referral. In a recent case against a physician and the managed care plan, the court referred to the practice of penalizing doctors for making too many referrals and rewarding them for "skimping on specialized care," as a referral-discouraging approach to health care," which the plan had a duty to disclose to the patient. Shea v. Esensten. et al., 107 F.3d 625 (8th Cir. 1997) Courts are adopting the patient's perspective when determining whether information about financial incentives should be disclosed. For example, the Shea court found that from the patient's point of view, a financial incentive scheme put in place to influence a treating doctor's referral practices when the patient needs specialized care is certainly a material piece of information. This kind of patient necessarily relies on the doctor's advice about treatment options, and the patient must know whether the advice is influenced by self-serving financial considerations created by the health insurance provider. The patient has a right to know the plan offers financial incentives that could color the doctor's medical judgment about the urgency of a referral to a specialist.

The Shea case opens the door for lawsuits by patients (plan participants) against carriers. However, that is not to say that the physician' s participation in the care and the physician' s independent duties to the patient will be overlooked or excused.

Some physicians have tried the defense of "the carrier made me do it." It hasn't worked.

Be aware that this is a developing area of the law. Much has been written on the topic. If you are interested in a more in-depth information, articles, statements , or recent legislative developments, feel free to contact Montgomery Little & McGrew, P.C.

At press time, an amendment to Colorado's anti-gag clause statute had just passed both Houses and is currently awaiting the Governor's signature. House Bill 1122 adds a provision addressing financial incentives. As currently written it provides that "a carrier shall not penalize a provider because the participating provider, in good faith, reports to state or federal authorities any act or practice by the carrier that jeopardizes patient health or welfare, or because the participating provider discusses the financial incentives or financial arrangements between the provider and the managed care plan." We will update you on this legislation in July.

CMS Med Fax

Colorado Medical Society provides the following listings of events as a member service only. Some events are approved for Continuing Medical Education credits. Information is provided by the sponsoring organizations. For more details, use the telephone contact at the end of the listing.

Colorado Dept. of Public Health & Environment
Managing Stress for STD/HIV Professionals
June 3, 1997
Pueblo, CO
Contact: Michael Murphy (303) 692-2766

Leigh Truit, MD, et al.
Leaving the bedside? Yes or no?
June 6, 1997
Denver, Colorado
Contact: Elizabeth Kraft at (303) 333-0900

Colorado Hospital Association
Managing Your Environment of Care
June 9-10, 1997
Denver, Colorado
Contact: Peggy McCreary at (303) 758-1630

Colorado Hospital Association
Hospital Accreditation Standards and Survey Process: The Advanced Course
June 13, 1997
Lakewood, Colorado
Contact: Peggy McCreary at (303) 758-1630

The Given Biomedical Institute
Genetics Ethics in the 21st Century
July 18-20, 1997
Aspen, Colorado
Contact: Linda Woodstock at (303) 372-9050 or 1-800-882-9153

Colorado Society of Osteopathic Medicine
Annual Meeting
July 25-27, 1997
Vail, Colorado
18 hours AOA category 1-A CME and Physician Asst Crdt.
Contact: Patricia Ellis at (303) 322-1752

America College of Cardiology
11th Annual Echocardographic Symposium on 2-D and Doppler Echocardiography at Vail
July 27-31, 1997
Vail, Colorado
27.5 Category 1 AMA CME credit
1-800-253-4636, ext. 695

American College of Cardiology
14th Annual Santa Fe Colloquium on Cardiovascular Therapy
September 25-27, 1997
Santa Fe, New Mexico
17 Category 1 AMA CME credits
1-800-253-4636, ext. 695

Physician sought

The Colorado Medical Society (CMS) is a member of the Coalition for a Tobacco Free Colorado (CTFC). As CMS has a respectable amount of policy on tobacco issues, and the work of CTFC is representative of policy CMS works to forward, it is important for CMS to support the Coalition.

There are several committees working on various projects such as youth tobacco use prevention, legislation and public awareness initiatives. If you are interested in tobacco use prevention issues, this is a terrific opportunity to become involved.

Please contact Suzi Shevell at 303-779-5455, ext. 2407 for more information about participating in the Coalition's efforts.

Send us your calender items.

If your specialty society or hospital is sponsoring a CME event or seminar which would be of interest to physicians in Colorado, have them send the information to: Event Calender, *Colorado Medicine*, P.O. Box 17550, Denver, CO 80217-0550. Please include information detailing program sponsor, date, location and phone number for more information.

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Executive Director's Update



Sandra L. Maloney
Executive Director
Colorado Medical Society

Another "hat" that I proudly wear is that of President of the Colorado Health Professions Panel (CHPP). I am very pleased to report that the Colorado Trust has announced an award of $703,200 to support the work of the Panel until 1999. The Panel was established by the Trust in 1994 to implement strategies to ensure that Colorado's supply and distribution of health care professionals are adequate to meet the future health care needs of the people of the state.

The new award, which is in addition to the $1.4 million that the Trust previously committed to support the Panel's activities, will enable the Panel to expand its membership and pursue three main goals. Those goals are to:

- Develop a system to collect information from the licensure process about the numbers and locations of health professionals across Colorado;
- Bring together those who employ health professionals in Colorado and those who educate them to design educational processes that will prepare health professionals to meet Colorado's future health care needs; and
- Ensure that all Colorado residents have access to appropriate primary care practitioners regardless of geographic, financial or cultural-linguistic barriers.

The current 25 member Colorado Health Professions Panel is made of up leaders from health care, business and government, as well as individuals who are involved in the education of health professionals in Colorado. It is exciting to be a participant in this group.

Coloradans need the Colorado Health Professions Panel. No other independent organization strives to accomplish similar goals. As President I am happy to say that the Panel is an instrumental vehicle in addressing the issues and equipping Colorado communities with health professionals that have the knowledge, skills and attitudes that meet their needs.

In addition to studying issues related to the supply and distribution of health professionals across the state, the Panel has made mini-grants to help rural communities develop programs to bolster minority-student interest in health careers, and recruit and retain health professionals. CHPP has provided computer equipment for those who educate health professionals, and helped to develop and implement interdisciplinary and multi-disciplinary curricula for health professionals. The Panel has also promoted collaborative efforts such as the Mountain and Plains Partnership in Training project, and the Colorado Consortium on Nursing Workforce Development Colleagues in Caring project.

The seven over-arching goals of the Panel are:

1. Colorado directs it resources (fiscal, regulatory, and legislative) toward creating and maintaining a health professions workforce that meets the state's needs.
2. Colorado's health professions educators and employers collaborate to design education processes

(Continued next page)

"Coloradans need the Colorado Health Professions Panel."

Executive Director's Update
(Continued)

which better prepare professionals to meet the needs of Colorado residents.

3. Colorado's health professions' educators monitor education of health professionals to ensure a better fit between supply and demand for Colorado.
4. Colorado uses the licensure process to collect basic health professions workforce data which is analyzed and made available in a timely, user-friendly fashion to legislators, health policy planners, health professions educators, prospective health professionals, and the public.
5. Colorado's health professions' licensing and regulatory system protects the public and facilitates the best use of health professionals in meeting health needs of Colorado.
6. All Colorado residents have access to appropriate primary care practitioners regardless of geographic, financial or cultural-linguistic barriers.
7. Colorado's health professions workforce reflects the diversity of Colorado's population.

With these goals in mind, the Panel recently convened public forums to share information and obtain feedback regarding items 2, 5 and 6 (above). These forums were well attended and favorably received. By the end of May, the Panel hopes to have distributed a policy document which details discussion on the above mentioned goals.

If you desire a copy of the summary document from any or all of the forums, or wish to receive a copy of the Panel's policy document you may contact the Panel offices at (303) 832-1109. Of course, you can always contact me directly at CMS. I am happy to provide any additional information.

CMS Call for Nominations

A call for nominations has been announced, seeking nominees for the offices of Colorado Medical Society President-elect, Speaker and Vice-speaker of the House, and Delegate and Alternate Delegate to the American Medical Association.

Nominations may be made by CMS members at large, either through component societies, or to the CMS direct. Self-nominations are accepted as well. Nominations must be received by June 1, 1997. Mail the nominating letter and the nominee's curriculum vitae to the: ExecutiveDirector, Colorado Medical Society, P. O. Box 17550, Denver, CO 80217-0550.

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Here's Our Agenda

It's simple. It's straightforward. And it represents the future of medicine. The American Medical Association presented to the Republican and Democratic leadership this agenda for the upcoming 105th Congress. Your AMA membership strengthens our voice in support of physicians and their patients. . . and will enhance our efforts to turn these goals into reality.

- **Patient Protections** Above all, preserve the ability of physicians to act as advocates for their individual patients. Do not allow insurers to "gag" physicians or withhold medically necessary treatments from their patients.

- **Medicare Reform** Make the Medicare program solvent. Expand patient choice of plans. Allow future growth rates that cover patients needs. Retain special protection for the vulnerable and elderly.

- **Medical Education and Research** Continue to support medical education and research so we can find cures for killers such as AIDS and cancer.

- **Public Health Problems** Expand prevention and treatment programs to combat AIDS, drug abuse, smoking and violence. These problems cost billions of dollars and millions of lives.

- **Liability Reform** Enact meaningful liability reform to ensure fair compensation to patients with legitimate claims while eliminating excessive malpractice awards that lead to defensive medicine.

Join or renew your membership in the AMA today — call 800 AMA-3211

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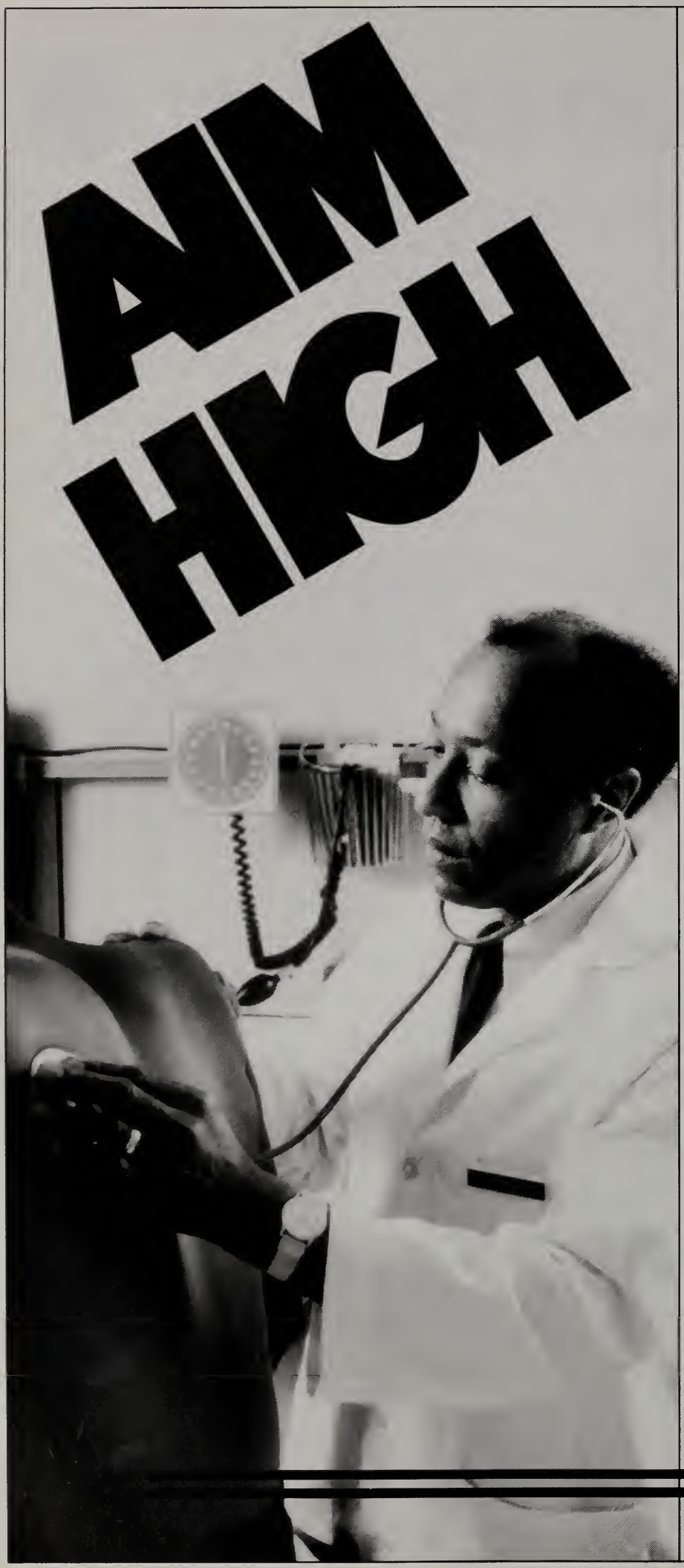
by Richard Allen, MD,
Co-Chair , CMS Council on Legislation

Legend: Class I- Actively lobby; Class II- Submit Comments; Class III- Passively Support/Oppose; Monitor - Watch for Amendments

The Council on Legislation has completed its work for the 1997 legislative session and will hold a "wrapup" meeting on June 6. We reviewed and prioritized a total of 31 bills and nine of those received high-priority status. A copy of the priority list follows for your information. You may contact the CMS Department of Government Relations for additional information on any of the bills listed herein. We shall provide more detailed information on the major bills in the July issue of Colorado Medicine when the legislature has adjourned.

CMS Legislative Prioritization List

BILL #	SUBJECT	POSITION	STATUS
Class I Priority			
SB 5	Medicaid Managed Care	Amend/Support	Passed Senate
SB 64	Fee Schedule for PIP	Oppose	Bill Killed
SB 222	License Fee Subfund	Oppose Cap	Awaiting Governor Sign.
HB 1017	Chiropractic Prescription	Oppose	Bill Killed
HB 1122	Consumer Protection	Support	Awaiting Governor Sign.
HB 1139	Prescription of Antiobiotics	Oppose	Bill Killed
HB 1161	Utilization Review	Support	Awaiting Governor Sign.
HB 1311	Uniform Disclosure	Support	Passed
Class II Priority			
SB 41	Uninsurable Health Plan	Support	Passed
SB 54	Conforming Amendments to Kassebaum/Kennedy	Support	Passed
SB 66	Safety of Emergency Personnel	Support	Killed in Appropriations
SB 98	Tobacco Use by Minors	Support	Killed in Appropriations
SB 127	Health Insurance	Oppose	Bill Killed
SB 130	Substitution - NarrowTherapeutic Index Drugs	Support	Bill Killed (poss. late bill)
HB 1050	Exemptions State Licensing Requirements - Physicians	Amend/Support	PI'd by Senate sponsor
HB 1088	Cigarette Vending Machines	Support	Awaiting Governor Sign.
HB 1094	Information Provided by Health Care Professionals	Support	Killed in Appropriations
HB 1095	Hearing Screening - Newborns	Support	Passed House
HB 1104	Insurance Provisions - Pain	Support	Passed
HB 1133	Unlawful Sexual Behavior	Oppose	Awaiting 2nd reading
HB 1147	Prohibition Against Tobacco Use in Schools	Support	Killed in Senate
HB 1157	Patient Access to Medical Records	Amend/Monitor	Passed
HB 1188	Disciplining Physician Solely for Treating Intractable Pain	Support	Passed
HB 1192	Health Care Coverage for Neuro-bio. Based Mental Illness	Support	Signed by Governor
Class III Priority			
SB 82	Immunization of Children	Support	Passed
SB 85	Female Genital Mutilation	Support	Passed Senate
HB 1091	Tobacco Products Information	Support	Bill Killed
HB 1039	Soliciting Accident Victims	Support	Passed
Monitor Only			
SB 24	Use of Title "Optician"	Monitor	Passed
HB 1183	Health Care Options	Monitor	Passed
HB 1239	Damages Limitations Adjusted to Inflation	Monitor	Passed



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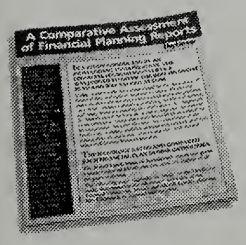
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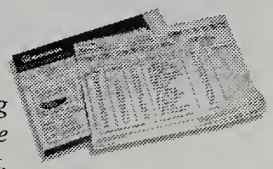
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Domestic Violence. . .
Mountain Communities Respond

"Physicians contacted us indicating an interest in learning how to deal with this problem in their practices."

The conference will be conducted in the all new, state-of-the-art Conifer High School, 1:00 p.m. to 7:30 p.m. on June 5, 1997.

Did You Know?

Colorado Medical Society's continued emphasis on physician awareness of possible domestic violence among patients takes on a new look at a one-day conference which will offer CME credits.

The conference, ***"Domestic Violence... the Mountain Communities Respond"*** is especially created for health care providers and concerned community members. A notable increase in domestic violence cases in Colorado's mountain communities coupled with the state's new domestic violence laws caused officials to take note. As a result, this training conference was put together to provide knowledge and skills for physicians, nurses and health care providers to assess, intervene, refer and report domestic violence cases.

Take a Break in the Hills

The conference will be held in Conifer, Colorado, and will be hosted by the Mountain Family Project, the Jefferson County Health Department and the Jefferson County District Attorney's Office, with in-kind help from other organizations, including the Colorado Medical Society. The conference will be conducted in the all new, state-of-the-art Conifer High School, 1:00 p.m. to 7:30 p.m. on June 5, 1997.

Registration is $35.00 for physician CME credits, $25.00 for non-CME. Fees include domestic violence protocol booklet, resource materials and dinner.

You and the Law!

Concerning physicians and the law, speakers include the Director of Jefferson County Health Department, Mark Johnson, MD, Dave Thomas, District Attorney 1st Judicial District including Jefferson and Gilpin Counties, and George Thomasson, MD, Vice President, Risk Management, Copic Insurance Company of Denver.

Goals of this conference:

The intended conference outcome is to create a community-wide protocol and resource network for addressing domestic violence in small communities, teaching the responsible parties to work together to curb or to report cases, and to show physicians the need to participate with community members in finding a solution to the problem. Domestic violence is not a problem for which one group can be expected to have sole responsibility. Although this may seem to be the fate of small communities where there are a limited number of willing problem-solvers, the small community plight drives the conference. There are many resources for such problem-solving easily available statewide in large or small communities.

For more information, call (303) 838-7552.

Don't let them Suffer in Silence!

Talking to your patients about domestic violence: How to encourage them to talk to you

Abuse and battering by a loved one creates a sense of betrayal that results in an *inability to trust others*. This distrust may extend to the victim's physician. Your patients will be hesitant to talk to you but, it is important and helpful to ask questions when you suspect abuse.

Understand that, to a victim, when a doctor does not ask how an injury occurred, it is another sign that the violence must be the patient's fault and there is no help. Victims may not respond immediately and may not respond as you think they should, but you will have taken a very important, potentially life-saving step.

- **Ask in different ways**. Not all victims will respond to the same kinds of questions. Victims' perceptions of what constitutes abuse differ dramatically and many will not equate what is occurring with the term "abuse".
- Maintain eye contact (when culturally correct).
- **Assume that any patient can be a victim** of domestic violence and that batterers can come from any family or economic background. The three professions with the highest abuse rates are law enforcement, law and medicine.
- It is important for the physician to recognize that victims are more than objects of abuse. They are **survivors**.

If you do suspect violence - Listen to your patients. Assure them that help is available for both them and their abusers. Ask if they are currently safe and provide them with resource information. Talk to your patients about your responsibility to report the abuse to law enforcement if you are treating injuries which have resulted from that abuse. Remember that your patient may need time before she/he is ready to accept help.

First and foremost remember that **you do not have to fix the problem**. But you are in a unique position to help your patients by:

1) recognizing domestic violence;
2) treating the injuries; and
3) referring patients to sources of safety, advocacy and support.

This month's domestic violence insert gives you specific questions you can ask your patients if you suspect they may be involved in domestic violence. It also provides some clues as to how to identify domestic violence. Please tear out the insert and utilize this information.

For additional resource materials please contact Ellen Stein at the Colorado Medical Society Offices - 930-0414 or 1-800-654-5653.

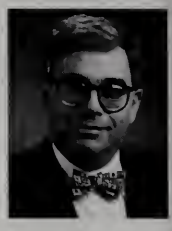


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Measurable Outcomes of Primary Care Curriculum are Numerous



by Richard D. Krugman, MD, Dean
University of Colorado School of Medicine

"Most important, perhaps, is the initial feedback from the preceptors and faculty."

This past fall, all third-year medical students began their final year of the University of Colorado School of Medicine's Primary Care Curriculum, thus completing the first full cycle of this new program. At the same time, the incoming first year students (Class of 2000) and returning second-year students are enrolled in this longitudinal course, which represents the first significant change in medical education at CU in some years.

In 1994, when the Primary Care Curriculum was launched, 132 primary care physicians in the Denver metropolitan area volunteered to mentor a student at their medical practice one afternoon a week. Most of those original mentors or preceptors are still working with the same student from the inaugural class. Meanwhile, the volunteer preceptor list has grown to 332 primary care physicians mentoring 385 students. Currently, 53 preceptors are working with more than one student.

The reasons for launching this course are multiple, the least of which is the exposure of students to primary care medicine. A recent report by the Institute of Medicine describes the important nature of primary care, including:

- its grounding in both the biomedical and social sciences;
- a clinical decision making process that differs from that used in specialty care;
- a sustained personal relationship between patient and clinician;
- the opportunity to promote health and prevent disease.

The assumptions that drives our efforts include the above and the belief that a health care system cannot exist without primary care services and that access to primary care improves lives. Our ultimate goal is to improve the health status of people, especially here in Colorado.

Specifically, the Primary Care curriculum focuses on four goals and objectives:

1. Clinical reasoning skill development.
2. Self-directed learning skill development.
3. Clinical skill development (i.e., appropriate interview and physical examination techniques).
4. Professional development.

The preceptors -- general internists, general pediatricians and family physicians -- receive clinical faculty appointments in the School of Medicine. This year, CU President John Buechner budgeted funds to supply all preceptors with e-mail accounts to make communications more efficient. More than 100 preceptors have already registered for this service. We also place a small library of books in each preceptor's office to assist in the learning process.

In addition to the many physicians who help students learn in their offices, more than 150 faculty and fourth-year medical students participate in on-campus sessions teaching and facilitating small groups of students. These groups work on problem-based learning exercises as well as practice physical examination and interviewing skills. The faculty working with these groups of students come from many backgrounds and areas of expertise including specialist physicians.

It is not clear, of course, whether the introduction of this course has resulted in more generalists. The first students (Class of 1998) to complete all three years of the program will match next year. However, there are some measurable outcomes of the

(Continued)

Measurable Outcomes
(Continued)

course's success to this point, notably the nearly 400 students are placed in 350 community-based clinical sites and the over 150 small group facilitators from varied disciplines who provide an opportunity for in-depth discussions of clinical experiences.

President Buechner supports this course as part of his Total Learning Environment (TLE) initiative. The TLE initiative recognizes the School's curriculum as beginning to achieve a balance between clinical and basic sciences and primary care and specialty care medicine. The "downstream" effects include the revision of clerkships to be more ambulatory and better integrated, and clinical electives in many departments that are now full, such as geriatrics and summer preceptorships.

Initiatives that have been implemented or expanded include Clinica Tepayac, a free clinic for underserved populations in West Denver; Warren Village, a free clinic for low income mothers and children; the Salvation Army free clinic for homeless people; and the Stout Street Clinic for the Poor and Homeless.

Most important, perhaps, is the initial feedback from the preceptors and faculty. Family medicine preceptors, for example, say they are experiencing a different student, one who appears more comfortable with patients and primary care practice. One family medicine preceptor said, "I used to strive for competence with my clerkship students: now I can demand excellence."

Though the program is still evolving, we at the School of Medicine are proud that we are balancing the medical education experience in Colorado and providing an invaluable experience for students, preceptors and patients.

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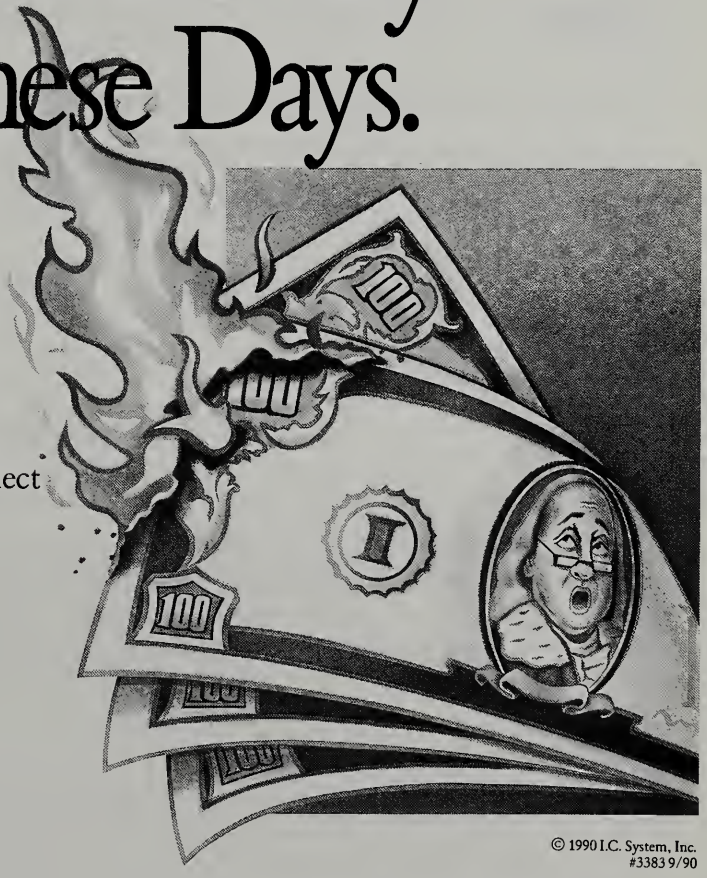
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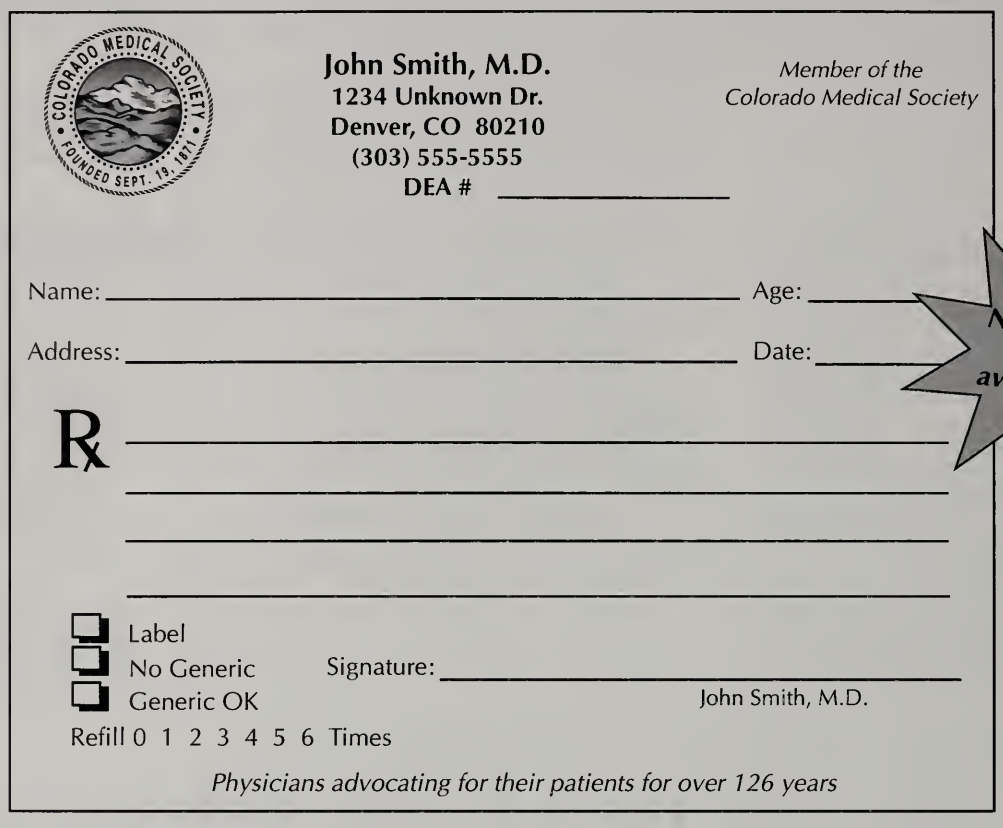


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Orders must be received by May 31, 1997 for this quarter's printing.

Order today and let your patients know that you are a proud member of the Colorado Medical Society advocating excellence in the profession of medicine.

Accountability and evidence-based health care: Foundations for a new era

Dear Colleague:

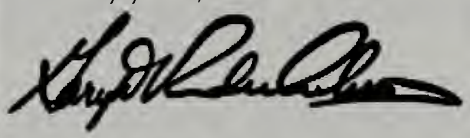
As your President-elect I have both the honor and responsibility to convene the Leadership Conference May 31 - June 1 of this year. Please accept my invitation to participate in the Conference and share your ideas, concerns, and suggestions as we focus on accountability, including the roles of both physicians and CMS.

The program will open with an overview of accountability and a review of what is being done to analyze outcomes. Then we'll look at challenges and opportunities, including some successful local innovative programs. Local, state and national initiatives will be reviewed. Everyone will leave this conference knowing what is being done in Colorado to move us into a new era of evidence-based health care.

For your convenience, a copy of the program, a registration form for the Conference and a reservation form for the Sonnenalp are included in this issue of *Colorado Medicine*.

Don't miss this conference! Make plans now to join me and other interested colleagues at the Leadership Conference at the Sonnenalp Resort in Vail on May 31 and June 1.

Sincerely yours,

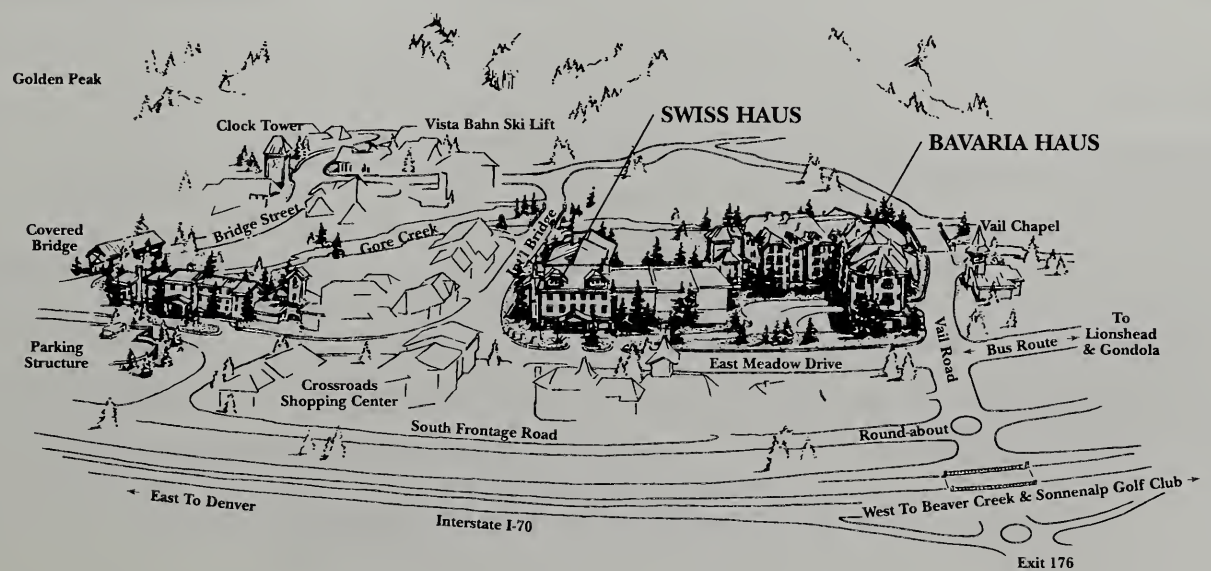


Gary D. VanderArk, MD
President-elect

Please fill out and return the accompanying registration form.

Map to 1997 CMS Leadership Conference

Vail Village



Colorado Medical Society

Leadership Conference

May 31-June 1, 1997
Sonnenalp Resort, Vail

Registration Form

❒ I plan to attend the Leadership Conference to be held May 31-June 1 at the Sonnenalp Resort in Vail, including dinner on Saturday night.

❒ My spouse/guest will attend the Conference and
❒ Lunch ❒ Dinner on Saturday

❒ My spouse/guest will not attend the Conference but will come to dinner on Saturday night.

Name: _____ Component Society: _____

Name of Spouse/Guest (if attending): _____

Mail to CMS, P O Box 17550, Denver, CO 80217
or Fax 303-771-8657

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Colorado Medical Society Leadership Conference

May 31-June 1, 1997, Sonnenalp Resort - Vail, Colorado

oUtCoMeS

Where do *YOU* fit in? Where does *CMS* fit in?

Saturday, May 31

Accountability

8:00 am –	8:30 am	Check in - Continental breakfast
8:30 am –	8:45 am	Introduction - Gary VanderArk, MD, President-elect
8:45 am–	9:15 am	Overview - Ned Calonge, MD

Who's Doing Outcomes: Nationally?

9:15 am –	9:45 am	AMA-AMAP - Bill Jessee, MD
9:45 am –	10:15 am	JCAHO-ORYX - Alfred S. Buck, MD
10:15 am –	10:30 am	Break
10:30 am –	11:00 am	NCQA & HEDIS - Andy Wiesenthal, MD
11:00 am –	11:30 am	National Spinal Cord Injury Registery - Gail Whiteneck, PhD
11:30 am –	12:00 pm	Medicare - Mary Kay Smith
12:00 pm –	1:00 pm	Lunch

Who's Doing Outcomes: Colorado?

1:00 pm –	1:15 pm	CFMC - Tom Dunn, MD, and Caravel Systems Inc- Robin Daigh
1:15 pm –	1:30 pm	University of Colorado Medical Center - John Steiner, MD
1:30 pm –	1:45 pm	CMS Data Committee - Dennis Waite, MD
1:45 pm –	2:00 pm	Colorado Neurological Institute - Ron Kramer, MD
2:00 pm –	2:15 pm	Kaiser Permanente - Dave Berman, MD
2:15 pm –	2:30 pm	Colorado Department of Public Health and Environment - Patti Shwayder
2:30 pm –	2:45 pm	Break
2:45 pm –	3:00 pm	Medical Quality Management (MQM) - Roger Krapfl
3:00 pm –	3:10 pm	Cigna - Vernon Walters, MD
3:10 pm –	3:20 pm	FHP - Don Daeke, MD
3:20 pm –	3:30 pm	CPN/RMHMO - David Martz, MD

Concurrent Breakout Sessions

3:30 pm –	4:30 pm	Practice Outcomes - Ned Calonge, MD, Bill Jessee, MD, Gary VanderArk, MD Institutional Outcomes - Howard Shapiro,PhD, Alfred Buck, MD Colorado Hospital Association (CHA) Population-Based Outcomes - Patti Shwayder, Gale Whiteneck, PhD, John Steiner, MD, Steve Ringell, MD
6:30 pm –	7:00 pm	Cash bar
7:00 pm –	8:15 pm	Dinner

Sunday, June 1

8:00 am –	8:30 am	Continental breakfast

Local models that really do work

8:30 am –	8:45 am	Stroke data base - Don Smith, MD
8:45 am –	9:00 am	Rehab following orthopedic surgery - Don Eckoff, MD
9:00 am –	9:15 am	Back & Neck Surgery - Gary D. VanderArk, MD
9:15 am –	9:30 am	Preventive Care Utilization - Ned Calonge, MD
9:30 am –	9:45 am	Division of Work Comp. - Low Back Pain Treatment Guidelines - Kathryn Mueller, MD, MPH
9:45 am –	10:00 am	VHA Continuous Improvement in Cardiac Surgery Program - Karl Hammermeister, MD
10:00 am –	10:15 am	Results of outcomes in a GI endoscopy lab - Pete Baker, MD
10:15 am –	10:30 am	Break

What studies are valid & how do you interepret the data?

10:30 am – 10:50 am	A statistician looks at outcomes - Howard Shapiro, PhD
10:50 am – 11:10 am	A clinician/scientist's view - John Steiner, MD
11:10 am – 11:30 am	A clinician's view - Byron Jones, MD

Panel Discussion:Does CMS have a role in accountability?

11:30 am – 12:15 pm	M. Ray Painter, MD Sandra L. Maloney, Leigh Truitt, MD	Bill Jessee, MD Ned Calonge, MD Gary D. VanderArk, MD - *Moderator*

Academic doctors:

Who are they and why are they competing?



by Donald Eckhoff, MD

"Competition between academic and private physicians is inevitable as the tradition of teaching institutions has been and always will be to train their own competition."

Who are the academic doctors?

Decades ago there was a group of physicians who practiced "academic medicine" and they were supported in their endeavor by salaries generated from tax dollars. Contrary to popular opinion, these wholly supported "academicians" no longer exist. The need for academic institutions to grow forced medical centers to take the limited resources provided by state legislatures and leverage the money to add faculty. At many institutions, the University of Colorado Health Sciences Center (UCHSC) included, wholly supported salaries were broken into multiple partially-supported salaries. New faculty were hired with the understanding that they would generate the unsupported portion of their salary through billable services such as patient care and research. This strategy has allowed medical centers to grow their faculty ten fold larger than that supported by state resources, while decreasing state support of each academic physician salary to less than 10 percent.

This funding methodology has spawned a new form of academic physician. They must teach and perform research, but they also have to treat patients and bill for services to survive, much like their colleagues in full time clinical practice. One must realize the differences between the two in order to understand who academic physicians are and why they compete.

Academic physicians, rendering tertiary care, depend largely on community referrals. Many academicians also have groups of self-referred patients as a product of satisfied customers sending friends and relatives. These patients span the economic spectrum from fully insured to uninsured. Given the mission of a state institution to care for the underserved, the ratio of uninsured to insured (1:6) is higher than one might expect to find in the private setting. This typically generates a collection ratio which barely exceeds the overhead expense of the practice.

Academic physicians have overhead expenses?

A popular misconception is that academic practices are subsidized to the point that they have no overhead. In fact, they shoulder much the same kinds of overhead expense they would in private practice. Office space is subsidized much as it is in the private sector if the physician is hospital based or offices in hospital-owned space. Office support, consumable supplies, equipment, and the academician's salary/benefits are all paid from clinical earnings. Any equipment including computers purchased from pre-tax dollars belongs to the state and therefore does not accumulate equity in an academic practice.

It is important to clarify that taxes for the academic physician are different. At UCHSC there is a 10 percent Dean's tax that comes off the top of all collections to support academic growth and development. There is a 4.5 percent department tax levied to support non-revenue generating expenses in clinical research and education. These taxes are in addition to the federal, state

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Academic doctors
(Continued)

and local taxes to which all physicians are subject.

An issue of great concern to all physicians, academic and private alike, is that of malpractice insurance. Academic physicians pay their own insurance from clinical earnings, but the rate (approx. one percent*) is lower than that in the private sector (approx. four percent*). The lower rate is a product of a very aggressive risk management effort, a self-insurance pool that has been very well managed, and limited immunity afforded employees of the state. The latter issue is often a bone of contention between academic and private physicians as it is seen as unfair. Fair or not, without limited immunity most academicians could not afford to practice, nor take the risk associated with training new physicians. If there is a better solution to this problem, it has defied years of heated debate.

The practice issues are really no different for the academic or private physician in contemporary practice. The academic physician trying to cover salary and overhead is confronted with all the same hassles of managed care which include but are not limited to the decreasing reimbursement, increasing work load (phone calls, paper work, etc.), and increasing frustration with bureaucracy (gate keepers, etc.). Practice profiling is a big issue for the academic physician trying to teach residents and not acquire a resident-like profile in the process.

Despite of, or because of, all of the similarities between the academic and private physician described here, competition between academic and private physicians is inevitable as the tradition of teaching institutions has been and always will be to train their own competition. Competition has to occur or the teaching institution has failed in its effort to fully train new physicians that can do all that their mentors do. To the extent that academicians take care of patient populations that private physicians prefer not to treat, i.e. indigent patients, there will be limited competition. But if academic physicians limit their care to the indigent, the highly leveraged academic institution has no future. The traditional challenge for academic physicians is to continually redefine the practice of medicine, inventing new and different ways to treat disease, thereby defining new ways to generate greater than 90 percent of their salary. The current economy will not continue to support this expansive approach to medicine, where academic and private physicians compete in the increasingly competitive and constrained environment of managed care.

It is managed care, after all, that forces the academic physician into competitive bidding for contracts to care for the insured patient. Understanding that there is little economic difference between the academic and private physician competitively bidding for these contracts will hopefully engender friendly competition. The academic physician and the private physician ultimately have the same goal – to offset the uncompensated care with enough compensated care to pay the mortgage and send the kids to college.

*(*rates based on gross earning of Orthopedists at UCHSC)*

Colorado Physician Network, Inc.



by David C. Martz, MD, President, Colorado Physician Network

"May Day!"

Traditionally May Day celebrates the advent of Spring. The "lion and lamb" schizophrenic month of April is over, and the earth is exploding with new growth.

And so it is for Colorado Physicians Network this year! We are delighted to report that both physician contracting and employer recruitment in the Front Range are moving forward vigorously. Contracts with hospitals and PHO's and IPA's are approaching completion. Marketing analysis is in full swing. A new series of town hall meetings are being scheduled in the Front Range areas to update physicians on implementation of Rocky Mountain Physicians' Choice in your office.

Did you know that the international distress call of "May Day! May Day!" is derived from the French "m'aider" which means "help me"? We continue to hear cries for help from patients, friends, and acquaintances who find themselves barricaded from physicians by health care plans that emphasize cost cutting over access, choice, and quality. Likewise physicians continue to struggle with denials and impediments to personalized and individualized health care. It takes time to get our message heard, but we continue to believe that Rocky Mountain Physicians' Choice will do it right for one and all.

Spring--at last--is here! Let us rejoice in the opportunities for growth that it brings. And watch for the Town Hall meeting coming soon to your area: join us in responding to the call of "May Day! May Day!" that echoes throughout our state.

Town versus Gown:
Competition Revisited

by John A. Sbarbaro, MD
University of Colorado Health Sciences Center

"I would note that this "competition by contract" began in the private sector —..."

I joined the faculty of the University of Colorado School of Medicine in 1990 after 25 years of building public and private institutions committed to serving large segments of the metro-Denver population. Each of those institutions had developed residency training programs, continuing medical education programs, and new technologies as a means of demonstrating that it was in the forefront of medical care. I was often told that these additions were directly competitive with the University - but they were programmatic efforts strongly supported by each institutions' medical staff because they were seen as a means of attracting both patients and additional primary care physicians.

Now that I've joined the faculty of the School those same private physicians are challenging me on why the University is "competing" with them for the care of patients. Perhaps because I've had the opportunity to view this elephant from both sides - and sometimes from the inside, I was asked for my perspective on the issue.

One fact has become very apparent to me: the driving mission of the University is truly different from other health care institutions in the state. Its leadership - both administrative and faculty - are focused on education and research. Advancement within the faculty depends upon evidence of continued proficiency in at least one of these two areas. Obviously real live, breathing, walking and talking patients are necessary for both the education and clinical research activities, and thus the third mission - service to patients. And for decades this service mission was focused on care to the disadvantaged, an issue that can still be counted upon to generate genuine faculty concern.

Unfortunately, all three missions - education, research, and care of those in need - require MONEY. Money issues, unfortunately, too often produce but little light. So let's talk money!

Where do faculty members get the salary that allows them to fulfill these three missions? (Salaries that in most cases are measurably below the income earned in the private sector.) Well it sure isn't taxes!! The average clinical faculty salary support from taxes is 13% and dropping. Research dollars now only pay for that portion of the faculty salary that can be confirmed by audit as the actual faculty time committed to that research.

Therefore, a large proportion of the existing faculty salaries must be generated through patient fees. Needless to say - Medicare, Medicaid, and Tri-care are not great payer sources! And just as in the offices of private physicians, commercial insurance payments have plummeted - barely covering the faculty salary involved in the time of providing care. The impact of these reduced payments is magnified by the transfer of 10+% of the earnings that are needed to support the costs of running an academic institution - specifically the Dean's office and the educational overhead of the specialty departments.

As a result, to earn their salary

(Continued)

Competition Revisited
(Continued)

the faculty have no alternative but to increase the percentage of care they provide for commercially insured patients. However, the ever increasing number of patients - including the faculty's traditional patient base of Medicare and Medicaid - now enrolled in managed care plans - has forced the faculty to seek contracts with these health plans. It's no secret that contracting with a managed care plan requires negotiation both in price and in service responsibilities. So indeed the faculty, as a multi-specialty group practice, often finds itself being placed in competition with colleagues in private practice.

On the other hand, I would note that this "competition by contract" began in the private sector — with some contracts specifically excluding the University as a care giver - contract conditions inserted at the insistence of contracting private groups. In reality, the "town" has long competed against the "gown" -- most recently exemplified by the aggressive efforts of Columbia, a for-profit institution, to dissemble the Children's Hospital - an action that would appear to serve no one but has the enthusiastic support of some "town" pediatricians.

The long term efforts of many hospitals and obstetricians to divert the University's traditional Medicaid population into their private delivery suites certainly continues unabated. And perhaps most telling is the Columbine Medical Group's unremitting blockade of any referral to the University, even when the referral is strongly supported by the patient's own Columbine primary care physician and there is no increased rate of payment.

Recognizing that most of Colorado's physicians are graduates of its School of Medicine, perhaps the real questions that should be asked are: "is the faculty competing with those they have trained?' or "are those that they have trained competing with the faculty?" Appears to me that the answer to both questions is "yes". Hopefully, the competition will be "collaborative competition" reflecting the framework of mutual respect and professionalism that existed during our years of formal training and will not corrupt what I believe to be the last of the "noble" professions.

Dr. Sbarbaro is a former President of Colorado Medical Society

Call for Nominations
1997 Physician Award for Community Service

***The Physician Award for Community Service*, sponsored by Wyeth-Ayerst Laboratories, is designed to provide recognition to men and women who are actively engaged in the practice of medicine but who, for whatever, reasons, give services above and beyond the call of medical duty.**

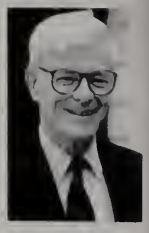
The award was established in 1961 in appreciation for the time and personal sacrifice devoted by physicians to the welfare of their communities.

The Colorado Medical Society is now taking nominations for this award to be presented at the annual meeting in September. Nominees must meet the following criteria:

1) The nominee must be a licensed Colorado physician;
2) The nominee must be living; no posthumous awards are permitted;
3) The nominee must not have received this award previously;
4) The nominee must have compiled an outstanding record of community service.

Please help to promote the image of the medical profession in its ongoing efforts to be a positive participant in community life. Nominate a colleague today! Nominations are due on or before June 30, 1997. Please call 779-5455 Ext. 2425 or 1-800654-5653 for more details.

Cloning Joe



by Thomas H. Coleman, MD

Guest editorial

"The Joe Camels are winning."

Who knows R.J. Reynolds Tobacco Company is pushing nicotine for kids? Everybody, including Reynolds and the kids. The company says their Joe Camel isn't a pusher. Same company that lied to the Congress, denying that nicotine is addictive. They know it is. They've been tinkering with the dose for years.

As part of their marketing program called YAS, for Young Adult Smokers, Reynolds learned that 95 percent of teenagers 14 to 18 recognized Joe Camel and his connection with cigarettes. Reynolds' share of the youth market had tripled to 13 percent, from four percent. That told Reynolds that Joe Camel was working. With colossal chutzpah they have triple-cloned him to thousands of huge billboards, qualifying for a first prize in gross art, bad taste and greed. Cloning a sheep to one ewe named Dolly is no threat to the human race compared to this cloning of three camels from one called Joe. Cigarette makers know their cash flow will slow as older addicts die, too young, of heart attacks and suffocation. For replacements they have to clone hundreds of thousands of new young addicts, as early in their lives as possible, every month, every year.

Cigarette makers know that teenagers' instincts for belonging to their "cool group" is stronger than the instinct of survival, especially if they believe they are immortal, or hopeless. They don't fear cancer or their empty lungs 30 years out, they fear ridicule and rejection right now from their smoky role models and smoky pals. That fear will send them anywhere to find their smokes. Trying to legislate the sale of snuff and cigarettes by demanding I.D. from anyone who "appears to be under age 27" won't help much. The Surgeon General's warning labels haven't helped anyone except tobacco companies when they're sued in court. "You have read the warning label? You kept smoking anyway? Whose responsibility is that?"

Rising rates of disease and death from using tobacco don't impress even adult smokers. Those things happen to "other people." Walk past any hospital. See the nurses on their "breaks," shivering in flimsy sweaters, hugging themselves with their folded arms, a cigarette between two fingers to keep their addiction warm. They know better. The Virginia Slims are winning. See the teener, slouching along on the sidewalk, sucking and blowing smoke with exaggerated display. They say they won't quit. They know they can't. The Joe Camels are winning.

Nicotine is one bad thing. Smoke is another. Philip Morris Company has admitted that cigarettes are gadgets for delivering nicotine to the brain for that "good feeling." They also deliver a cloud of toxic gas to the lungs for cancer and heart attacks. R.J. Reynolds knew that in 1988, marketing a relatively smokeless cigarette, "Premier." They withdrew it after five months. It didn't taste good and was slow to light. Also, it didn't sell. Cigarette makers don't care how they keep smokers addicted. They urge them to enjoy "taste," and all the gestures that waste time and look "sexy," whatever that means.

If we suddenly discovered Congressmen and any other drug company conspiring to profit from distributing an addictive drug to children that

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Cloning Joe
(Continued)

cripples and kills, costing us chronic misery and billions of dollars, how long would it take for rage and outcry to demand trials and convictions? For the tar in cigarette smoke, why not tar and feathers for its makers?

There are only a few cracks and crumblings around this strange comfort of Big Government with Big Tobacco. One cigarette maker, Liggett, has decided to come clean about deception in the industry, exposing secret papers that may force other companies to come clean themselves. States are suing Big Tobacco for their expensive care of sick smokers. Investigators for the federal Trade Commission urge further legal action against Joe Camel. The Federal Drug Administration wants to regulate nicotine.

Now Big Tobacco is offering the Government a multi-billion dollar bribe for permission to continue selling nicotine and cancer to its addicts. For Government to take that bribe would be an epic compromise with evil, good for lawyers and Big Tobacco, bad for ordinary people and their children.

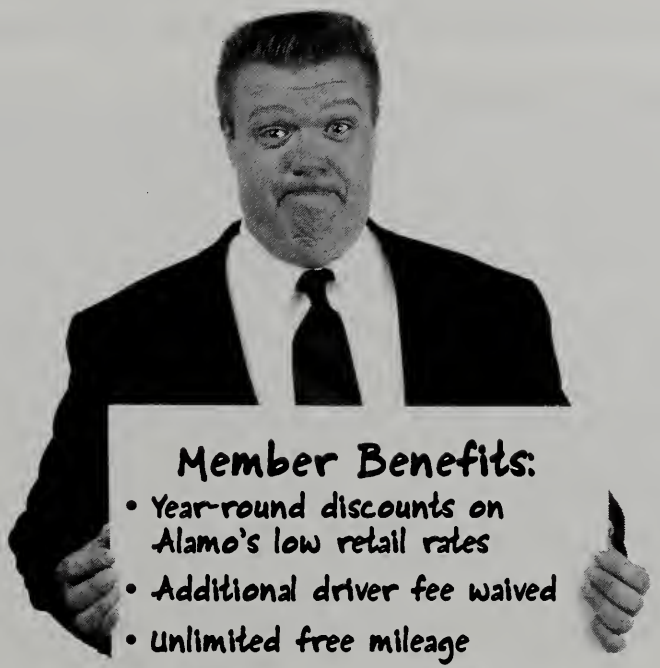
Is anyone else out there wondering how much longer we have to watch this charade? What will work? Nothing, until the tobacco companies admit they are poisoning their prisoners to death. Nothing, until the Congress quits subsidizing tobacco. Nothing, until the Treasury breaks its own addiction to money from the tobacco tax. Especially nothing if we don't educate young people that tobacco is dangerous. That should begin right now, where we have the advantage. In kindergartens, and all the way through high school.

It's long past the time. Why are we so slow?

What do you think? Please send your responses to: Letters to the Editor, Colorado Medicine, PO Box 17550, Denver, CO 80217-0550

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CopicComment

by Jerome M. Buckley, MD
Chairman & CEO
Copic Insurance Company



Copic's Risk Management Department to Shift Focus to Disease-Based Management

For the past few years, Copic has seen relatively flat to decreasing frequency rates accompanied by increasing severity. In 1994 the average severity across all classes was $34,567. In 1995, it was $36,414. And in 1996, it increased to $37,882. In other words, our physician policy holders are being sued less often, but the dollar damage is getting worse each year.

Copic's claims data shows that five specific types of claims account for the majority of losses. In order they are:

Type of claim	Severity ($ incurred)	Frequency
Delayed dx of cancer[1]	$19,645,285 (1)	360 (2)
Adverse drug reaction	$14,977,637 (2)	475 (1)
Delayed dx of breast cancer	$9,655,741 (3)	203 (3)
Acute myocardial infarction	$9,477,836 (4)	162 (4)
Delayed dx of colon cancer	$3,220,317 (5)	42 (6)
Laparoscopic cholecystectomy	$2,579,400 (6)	39 (7)
Communication problems	$1,855,494 (7)	137 (5)

[1] Excludes breast and colon cancer

In reviewing these data, George O. Thomasson, MD, Vice President of Copic's Risk Management Department, recognized that (with the exception of laparoscopic cholecystectomy) these are potential "trouble areas" for almost ***any*** physician, regardless of his or her specialty. This realization is the impetus behind the Risk Management Department's anticipated move away from a specialty-specific focus and toward a broader, disease-based approach to physician risk management education.

At this time, Copic has research in progress in evaluating the best way to design a disease-specific risk management program for breast lumps and acute myocardial infarction. Obviously, such a program must be broad enough to address the specific parts played by the primary care provider as well as the specialty-specific physician(s) – mammographers, biopsy providers, surgeons, and oncologists. The responsibility and the role played by each of these physicians must be properly integrated in any effective disease-specific risk management program. Most importantly, the communication "ball" must not be dropped by any physician, and the proper message –and the proper follow-up to that message– must be conveyed to the patient at all encounters.

Similarly, the complete risk management program for chest pain and myocardial infarction will require the same coordinated relationships and care among the emergency room physician, the primary care physician, and the therapeutic interventionalists (cardiologists or cardiac surgeons.)

With a little imagination, one can envision a future risk management seminar where all of these professionals, including their support professionals (PAs, APNs, and NPs), are in the same room. The appropriate practice guidelines, alternative treatment modalities, tickler systems, and the effective communication of all components are simultaneously delivered to this integrated audience. The value of such specific disease management seminars quickly becomes self-evident. Disease management systems are clearly upon us and appropriate risk management systems must be part of that same future.

Dear CMS:

It was Indeed a great honor and surprise to find I was one of the recipients of your award "In Recognition Of Those Serving Colorado's Underserved." Ms. Sherry Wasserman has graciously shared with me your activities that day. I only regret I was unavoidably out of town and unable to attend. Certainly many of us feel now, more than ever, the increasing need for care of the underserved. State medical societies have indirectly played a significant role in my life. A role model and mentor, my father, Dr. Clarence Eneas Toshach, born in 1894, was president of the Michigan State Medical Society and the local medical societies. In the late 1930s, by studying nights he became a board qualified obstetrician and gynecologist- -an infant specialty at the time! In conjunction with the University of Michigan he developed and mentored an ob-gyn residency program which exists to this day. The residents referred to him as "The Big T." He was fair, honest and demanded excellence in all things, but especially in patient care.

Medical school was achieved by riding the "el" (elevated rail-city-trolley) to Bellevue Hospital/New York University. His equivalent of the Physician's Desk Reference (PDR) is a Bellevue pharmacopeia with about 30 pages and some hand written notes about how to make formula with evaporated milk- --- something I still learned in nursing school in 1953. Dr. Toshach settled in Saginaw, Michigan about 1920. He made a vow to himself that for the first 10 years of practice he would never refuse a call for help. As the town had one phone operator who "switchboarded" all calls (not everyone had a phone then) she quickly learned about the doctor who never said "no", night or day. He kept his vow. As the first public health officer he campaigned for not spitting (TB was still rampant), for people to clean up their back yards and for immunizing, as vaccines became available. Years later, as I occasionally accompanied him on house calls in the summer evenings, he would quietly remark about the tidy yards. Also in the early 1930s he and my mother overcame many obstacles to establish the first planned parenthood clinic in the area. They even had the endorsement of the early labor unions. A general health clinic was established in the poor part of town and every week he helped provide services. Both then and during the war, payment was often in the form of eggs, butter, chickens. December 7, 1941, the beginning of World War II, he was one month too old for active frontline duty. In World War I he had served in France. Now in 1941 his decision was to stay civilian. It was obvious there would be a great shortage or doctors on the home front. There was. He again worked as a general practitioner 20 hours a day, 7 days a week, general surgeries in the mornings, then office hours (and 35 plus deliveries a month) until 11 PM. Mom was the evening office help. In later years he did comment, "I knew I was tired back then when it took four hours to do gall bladder surgery". (And we now know what a blessing it was to have paper work that was an 8X5 Index card---period.) He always supported the nursing school, always taught the students and always attended their graduation ceremonies, He fully understood the role they played in patient care. He was Chief of Staff for many, many years. He trained his office nurse to do the monthly OB checkups and to do lab work. As such she was indeed a prototype nurse practitioner. He was a mentor and a role model for many, including me. The People's Clinic has provided an opportunity to work with

Recognition of those who "Care for Colorado's Medically Underserved"

(Continued next page)

Letters
(Continued)

wonderful people, both patients and staff. Thank you for the honor of the award, and the opportunity to reminisce.
Sincerely yours,

Susan T. MacFarlan. MPA,
Nurse Practitioner Cert
Physician Assistant-Cert

Reprint of Denver Post 4/23/97 article. By David Algeo

"Health insurers proffer plan to avoid legislation"

Health insurers in Colorado and other states, hoping to avert a crackdown by lawmakers, have devised a broad voluntary program to respond to consumer complaints and physician concerns, says Karen Ignani, president of the American Association of Health Plans.

Ignani was in Denver on Tuesday, talking with health-plan executives about the association's "Putting Patients First" initiative, a program designed to improve communication with patients and physicians and streamline administrative procedures...

Reprint of Letter to the Editor of the Denver Post

The proposal by the American Association of Health Plans initiative titled "Putting Patients First" strikes my curiosity. What have the health plans been doing before? This is the very reason that there has been such a dramatic backlash against managed care entities which are denying or limiting medical treatment, placing barriers between physicians and patients and failing to adequately disclose contractual arrangements, financial incentives and disincentives which affect medical treatment, and pouring health care premium dollars into outrageous CEO salaries and investor profits. It is time, as has been done in Colorado, for our government agencies to step in and protect the public from an unregulated managed care industry through patient protection acts. The people (our patients) are beginning to speak up and we need to hear from them.

If the AAHP truly wants to put patients first they should: advocate that their health plans encourage and support their physicians functioning under the ethical principles of the American Medical Association (which has put the patient first for the last 250 years), leave all final medical decisions to patient and doctor and pay for those treatments approved by the treating physician if covered within the health plan. They also should cap the limits of their profit and administrative costs and channel premium dollars into health care delivery, education and research.

Let's see the AAHP put their money where their mouth is. This is what our patients should be expecting.

Jeremy A. Lazarus, MD,
AMA Alternate Delegate, CMS

For a copy of the Denver Post article, "Health insurers proffer plan to avoid legislation," please call the CMS Communications Department at (303) 779-5455, ext 2525.

Call for Nominations
Colorado Medical Society Certificate of Service

Each year, Colorado Medical Society awards a physician with the prestigious Colorado Medical Society Certificate of Service, recognizing outstanding effort and devotion to the purposes of organized medicine. The award is given to an individual who displayed unusual efforts on behalf of the Colorado Medical Society, or noteworthy contributions to the practice of medicine in Colorado.

This award, given by the Colorado Medical Society Houseof Delegates at each year's Annual Meeting, goes to a physician named by his/her peers. You are urged to consider this award and the activities at both state and local levels, and nominate that individual whom you feel has made an outstanding contribution.

Nominations are due on or before June 30, 1997. Please call CMS at 1-800-654-5653 or (303) 779-5455, extension 2425, to request a nomination form.

CMS Physician's Financial Program

"Fee-based Brokerage Accounts--A new level of trust with your Financial Advisor"

by John W. Warner, Assistant Vice President
HWC Group

A recent study by the Boston research firm, Dalbar, found that Americans are distrustful of paying commissions for financial advice. Of those surveyed, 70 percent preferred to pay fees, like those charged by lawyers or CPA's.

Americans hate commissions. They can see nothing but the potential for conflict of interest in a situation where the advisor gets paid a commission regardless of whether the investor makes money or loses money.

Things are changing rapidly at brokerage firms. Focusing on financial planning and portfolio performance has steered many to a fee-based account program and away from the traditional transaction-based account. Some also add a number of other features to their fee-based account to better serve the client's needs.

A fee-based relationship-oriented business runs on the fuel of trust. This trust is definitely the fuel of the future for investors. Successful investing isn't about knowing; it is about believing. When the investment advisor believes, they will be believed. When the advisor is eminently trustworthy, because their compensation is based on the values of the investor's account, they will be trusted. The fee approach encourages advisors to help clients grow assets rather than switch from one investment to the other. This promotes long-term client-advisor relationships.

As a professional Financial Consultant at a national brokerage firm for the past 14 years, I can't explain how elated I am to see the industry move in this direction. When your career has been dedicated to doing the right thing for the client, it is reassuring to see the conflict of commission-based compensation disappear. The long-term successful relationship should be a goal for both investor and advisor. The fee-based account program is one major step

1997 Physician Financial Program Seminar Schedule*

May 15, 1997 - Glenmoor Country Club, Cherry Hills Village 6:30 pm**
- Health Care Services/Physician Practice Management/Medical Business Planner
- Financial Services On Line

May 22, 1997 - Glenmoor Country Club, Cherry Hills Village 6:30 pm**
- Health Care Services/Physician Practice Management/Medical Business Planner
- Financial Services On Line

July 10, 1997 - **Colorado Springs** (Time and location to be announced)**
- Health Care Services/Physician Practice Management/Medical Business Planner
- Financial Services On Line

August 14, 1997 - **Grand Junction** (Time and location to be announced)

September 25, 1997 - **Fort Morgan** (Time and location to be announced)

October 30, 1997 - **Durango** (Time and location to be announced)

December 4, 1997 - **Boulder** (Time and location to be announced)

* All dates and topics of seminars listed are subject to change.
** Attendance must be confirmed through HWC Group offices at (303) 689-8088 FAX: (303) 689-8050

Medicare fraud and abuse - HCFA definitions

by Grant Stffen, MD,
Medicare Medical Director for Colorado

Part Two of a Series

Overutilization, misrepresentation... Knowing the policing definitions could help prevent an investigation.

Dr. Grant Steffen, the Medicare Medical Director for Colorado, has furnished the following definitions which were taken directly from the "Medicare Fraud and Abuse" manual. This information is particularily timely given the renewed interest in this subject with the enactment of the Health Insurance Portability and Accountability Act of 1996 (otherwise known as the Kassebaum-Kennedy Bill). Look for an update next month on how this law has "beefed up" HCFA's anti-fraud investigations, including the increased penalties.

–Marilyn Rissmiller, CMS Dept. of Health Care Financing

The Fraud Unit is the area within the Medicare Carrier's operation that is responsible for investigating cases of suspected fraud and abuse, and developing such cases for referral to the Office of the Inspector General for consideration and initiation of criminal, civil monetary penalties and/or sanctions. These are the definitions they use when reviewing cases:

Abuse

Abuse describes incidents or practices of providers, physicians, or supplier of services and equipment that, although not usually considered fraudulent, are inconsistent with accepted sound medical, business or fiscal practices. These practices may, directly or indirectly, result in unnecessary costs to the program, improper payment, or payment for services that fail to meet professionally recognized standards of care, or which are medically unnecessary.

The type of abuse to which Medicare is most vulnerable is overutilization of medical and health care services. Abuse takes such forms as, but is not limited to:

- Excessive charges for services or supplies.
- Claims for services not medically necessary, or not medically necessary to the extent rendered (e.g., a battery of diagnostic tests is given where, based on diagnosis, only a few are needed).
- Breaches of assignment agreements, which result in beneficiaries being billed for disallowed amounts on the bases that such charges exceeded the reasonable charge criteria.
- Improper billing practices which include:
  * Provider exceeding limiting charge.
  * Submittal of bills to Medicare instead of third-party payers that are primary insurers for Medicare beneficiaries.
  * Violations of Medicare participation agreements by physicians or suppliers.

Although these types of practices may initially be categorized as abusive in nature, under certain circumstances, they may develop into fraud.

Fraud

Fraud is intentional deception or misrepresentation that the individual makes, knowing it to be false and that could result in some unautho-

(Continued next page)

Medicare fraud
(Continued)

rized benefit to them. The most frequent kind of fraud arises from a false statement or misrepresentation that is material to entitlement or payment under the Medicare program. The violator may be a participating provider, a supplier of durable medical equipment, a beneficiary, or some other person or business entity, including a carrier employee.

Fraud in the Medicare program takes such forms as, but is not limited to:

- Billing for services or supplies that were not provided. This includes billings for "no shows," i.e., billing Medicare for services that were not actually furnished because the patients failed to keep their appointments;
- Misrepresenting the diagnosis for the patient to justify the services or equipment furnished;
- Altering claim forms to obtain a higher payment amount;
- Deliberately applying for duplicate payment, e.g., billing both Medicare and the beneficiary for the same service or billing both Medicare and another insurer in an attempt to get paid twice;
- Soliciting, offering, or receiving a kickback, bribe, or rebate, e.g., paying for a referral of patients in exchange for the ordering of diagnostic tests and other services or medical equipment;
- Unbundled or exploded charges, for example, the billing of a multichannel set of lab tests to appear as if the individual tests had been performed;
- A provider completing Certificates of Medical Necessity (CMNs) for patients not personally and professionally known by the provider;
- Misrepresenting the services rendered (upcoding or the use of procedure codes not appropriate for the item or service actually furnished), amounts charged for services rendered, identity of the person receiving the services, dates of service, etc.;
- Billing for noncovered services as covered services, e.g., routine foot care billed as a more involved form of foot care to obtain payment;
- Claims involving collusion between a provider and a beneficiary, or between a supplier and a provider resulting in higher costs or charges to the Medicare program;
- Use of another person's Medicare card in obtaining medical care;
- Alteration of claims history records to generate fraudulent payments;
- False provider disclosures of ownership in a clinical laboratory;
- Split billing schemes (e.g., billing procedures over a period of days when all treatments occurred during one visit);
- Use of the adjustment process to generate fraudulent payments;
- Collusion between a provider and a carrier employee where the claim is assigned. (If the provider deliberately overbilled for services, adjustments could be generated with little awareness on the part of the beneficiary);
- A carrier employee acting on his/her own behalf where the claim is unassigned. (Through manipulation of beneficiary address or the claims history record, a carrier employee could generate adjustment payments against many beneficiary records and cause payments to be mailed to an address known only to him/her); and
- Billings based on "gang visits," (e.g., a physician visits a nursing home and bills for 20 nursing home visits) without furnishing any specific service to, or on behalf of, individual patients.

You're too busy practicing medicine to play politics

Every day you see the effects of health care reform on your practice. Every day you promise yourself that you will become more involved and help shape the future of medicine. But the truth is that sometimes you are just too busy.

Fortunately you have COMPAC. Legislators are becoming aware of and educated by organized medicine. However, the Campaign Reform Amendment and legislator turnover in both Houses in 1998 may dramatically affect the legislative advances made for you and your patients.

COMPAC

Join COMPAC today and become personally involved in the future of health care in Colorado. Then rest assured that voice of organized medicine will continue to be heard at the state legislature. For information call (303) 779-5455, ext. 2410 or 1-800-654-5653.

Archives

Snakes, pigeons and immunity

John L. Lightburn, MD,
Historian,
Colorado Medical Society



Henry Sewall, Ph.D., M.D., Sc.D.

"After trials through several thousands of years, civilized mankind is confronted with a snarl in the web of progress which threatens not only to block further development but to entangle and paralyze its artificers for future efforts."

Henry Sewall in **Society and the Natural Law**

Henry Sewall's ancestors exhibited a number of his character traits. His great great grandfather, Judge Samuel Sewall (1652-1730) presided over the Salem witch trials and possessed a temperament seen in Henry Sewall's fiery temper, his gift for invective and his monumental rages. On the other hand, Henry's gentle grandfather, Dr. Thomas Sewall (1786-1845) was known in early Washington as a research scientist, professor of medicine and a writer on medical subjects, and, like Henry, was struck down by tuberculosis at the beginning of his career. So much for genealogy.

Henry was born in Winchester, Virginia on May 25, 1855, the sixth of seven children. His father, the Rev. Thomas Sewall, known for his silver tongue in the pulpit, contracted laryngeal tuberculosis in his late thirties and spent the last decade of his life a frail and frustrated man. He died in the summer of 1870 when Henry was fifteen, deprived of the pleasure of seeing his son, Henry, matriculate in his alma mater, Connecticut Wesleyan in 1871. The strict, Methodist code he had learned from his father was reinforced during his five years at this Methodist college and remained scrupulously moral for the rest of his life. All through Wesleyan, his dream had been to enter Harvard Medical School, his grandfather's alma mater, but the estate left by his father was managed by an uncle who invested it in "gilt edged" securities which turned out to be worthless. So Harvard was out.



Dr. Henry Sewall, President of Colorado Medical Society, 1924

Serendipitously, another possibility presented itself. A new school was opening in Baltimore where his family now lived, a school established by Johns Hopkins to open in the fall of 1876. Since Johns Hopkins did not yet have a medical school, Henry chose physiology as his major and presented himself to Professor Henry Newell Martin and asked him for a job. The two young men took to one another at first sight and that day started an ideal teacher/student relationship that evolved into a fast friendship which lasted until Martin's untimely death in 1896. Johns Hopkins was a new and exciting place and Martin, who became the fountainhead of physiology in America, was a superb teacher who gave Sewall the foundation for becoming a great research scientist. With a Ph.D. in hand, Sewall left his beloved teacher for a travelling fellowship in Europe enriching his knowledge of medicine and physiology with Sir Michael Foster in London, Carl Ludwig in Leipzig and the famed clinics in Vienna.

Returning to Hopkins in 1880, he became a teaching assistant in physiology for a year at which time he accepted the chair in physiology at the University of Michigan. When he arrived in Ann Arbor, he discovered that physiology was not considered an important part of the medical school curriculum. He set about to correct that serious error with energy and eloquence. When it came time for the final examination, he was advised to conduct a trial exam on three of his best students. Their performance was so miserable



Dr. Henry Sewall in his attic laboratory at home. The wall calendar shows May, 1921. At that time, Dr. & Mrs. Sewell resided at 1360 Vine Street where they lived until Dr. Sewall's death in 1936. Even during his final hours, Dr. Sewall was "in full character, observing and recording." He was the lifelong student.

that he flew into a rages, telling them they knew nothing and would never succeed in medicine. The three were Franklin Mall, later to be professor of anatomy at Johns Hopkins, William Mayo, who later became a famous surgeon, and Walter Courtney, later chief surgeon of Northern Pacific Railroad.

Although he taught passionately, his first love was research, "to find out the WHY of common occurrences that people accept as self-explanatory". Overcoming lack of funding, he set up a laboratory in a dark basement under the school lecture hall. During his few short years in Ann Arbor, he published over a dozen original papers based on his research in the basement. Driven though he was to teach well and to find out WHY, the "malaise of the tubercle" began to deprive him of the necessary energy and by the spring of 1886, he could no longer ignore his illness, and completing his lectures, made his first trip to Denver where he recuperated for the summer.

With renewed energy and hope, he returned to his basement laboratory to begin his famous experiments with rattlesnakes and pigeons in which he demonstrated the principle of antitoxins. In the midst of his research and teaching, he found time to meet a lovely young woman, Isabel Vickers, from Toronto. They were married in 1887. Although much in love, their first year together was marred by the persistence of his "graveyard cough". Reluctantly, he applied for a leave of absence which was granted along with the unusual degree of Honorary M.D. (They wanted him back.) They returned to Colorado where they spent the summer on a ranch on the Grand River near Parachute. In the fall they returned to Denver where Isabel could recover from an attack of typhoid fever and Henry became acquainted with the medical community, lectured in physiology at the University of Denver medical school and, at the same time, enrolled as a student to earn credits toward an M.D. They both liked Denver and decided his health needed the dry, clean air of Denver's climate. So he submitted his resignation, but he was told that he was already scheduled to lecture that spring, and the resignation could not be accepted. After returning to Ann Arbor it soon

(Continued)



The Sewall home at 1360 Vine Street, Denver. *(Rocky Mountain News, April, 1961)*

became apparent that returning had been a mistake, and he could no longer ignore the fact that he had tuberculosis. After a year in Saranac Lake where he was patient, resident physician and laboratory technician under the famous Dr. Trudeau, he finally returned to Denver.

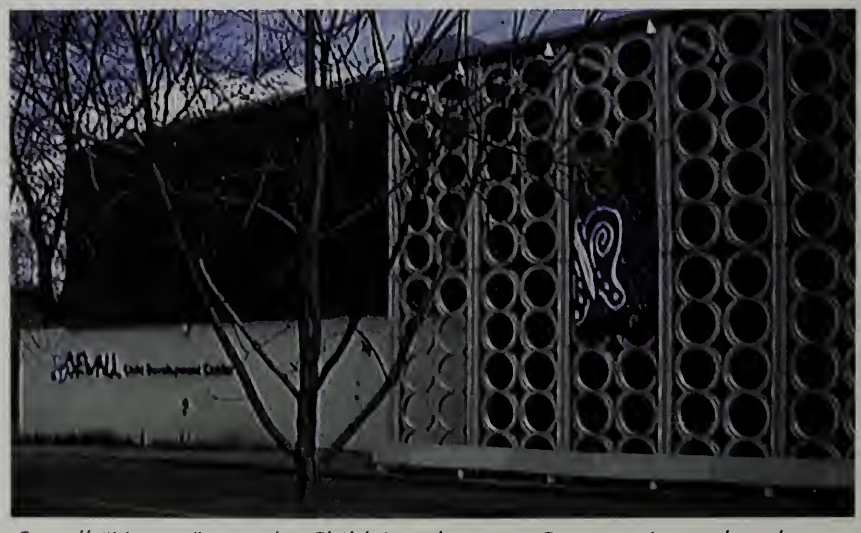
In Denver in 1890, he received his M.D. degree from the University of Denver and opened his medical office in his home at 23 Brinton Terrace on 18th Avenue where they lived for 13 years before moving to their final home at 1360 Vine. At Brinton Terrace, his home was not only his office but also his laboratory. Over Isabel Sewall's objections, there were cages of guinea pigs in the attic in the winter and on the front porch in the summer. In addition to caring for his patients and doing research, he also was professor of physiology at the newly created Denver and Gross medical college. But a full time practice, research and teaching were not enough to satisfy his drive. He was everywhere. He was assistant Health Commissioner of Denver under Henry Steele, 1891-93, Secretary of the Colorado State Board of Health, 1893-99. He was one of the founders of the Library of the Denver Medical Society and started the Denver Academy of Medicine. Perhaps he was trying to bring to Denver what he had been forced to leave back in Baltimore and Ann Arbor. When the Denver and Gross Medical School combined with the University of Colorado School of Medicine, he became chairman of the department of medicine at the new medical school, 1911-1918.

When National Jewish Hospital opened in 1899, he joined the staff there and soon became known for his special knowledge and skill in treating tuberculars. Collaborating with Henry Corper, he began many years of significant research in tuberculosis. He was on the National Research Advisory Board of the hospital. During his years in Denver, he published more than 140 original papers.

Yet, he was no laboratory recluse. He was president of the Denver Medical Society in 1916 and the Colorado Medical Society in 1924; he served on the National Board of Medical Examiners from 1915 -1919. He was president of the American Climatological Society in 1914; president of the National Tuberculosis Association in 1924. His interests were not confined to tuberculosis. For example, he noted on several occasions that his pulse became irregular when smoking a cigarette. He shared this observation with Dr. Canby Robinson who was working with one of the first electrocardiographs to be set up in the country at the Rockefeller Institute. The arrhythmia was recorded and Dr. Robinson speculated that it was caused by a shift in the pacemaker in the auricles.

He was known throughout the country and his contribution to Colorado Medicine was enormous. To quote from Allen K. Krause's eulogy, "...what shall we say of him whose faculties expand as age descends, whose insight grows the sharper each heaped up year; whose fancy plays more lightly yet more true; whose mind reaches out the more; and whose zest shows out more keen---to feel the freshness of the glittering sun, to soar with the new idea set free by some daily observation and put to test by ingenious experiment".

It was in this home on Vine Street, a retreat created by his wife and arranged in every detail to minister to the needs of the lifelong student whose persistent dream "to find out the WHY of common occurrences" that the end came, unexpectedly on a July morning in 1936. He died in full character, observing and recording, as described in *The Rocky Mountain News* "he reached for a tablet and pencil at the bedside. With faltering fingers, he wrote down the time and his temperature and noted that his skin was moist. Then he died".



Sewall "House," now the Child Development Center as it stands today.

Another legacy of Henry Sewall, MD.





Dr. Henry Sewall was a man of many talents and great depths. Driven by a desire to conquer his own illness, and a commitment to help others so afflicted, he devoted his life to research and cure. After he was physically taken from this world he went on helping and, to this day, the name Sewall is synonymous with teaching, learning and healing. The Sewall Child Development Center, which occupies the property where his house once stood at 1360 Vine Street, does welcome all, but particularly children.

Sewall offers education for children with special needs "associated with developmental delays, disadvantages and disabilities."

Sewall House Executive Director Cheryl Caldwell adds that the center brings teachers, therapists and parents together for development of the children's skills and self esteem. The Center also does developmental screenings and diagnostic evaluations. It provides individual occupational, physical, speech-language and play therapies. The Center also provides training for child care and preschool providers.

Know for many years as Sewall House, the Child Development Center is funded almost entirely by gifts, donations and grants. Dr. Sewell willed his home to the Society for Crippled Children and Adults, upon his wife's death. She died in 1944.



Ms. Cheryl Caldwell, Executive Director of Sewall Child Development Center with a portrait of one of the Center's special needs children. Michael was 2 1/2 at the time with Down Syndrome, is now 13 years old and in regular middle school classes.



Sewall House, as it was widely known for many years was a rehabilitation center. Today, it takes on those same challenges and many more, especially providing for children "a special place to learn & grow."

SEWALL
CHILD DEVELOPMENT CENTER

Trends in Medicine

Following are intersting trends in medical economics which we have gleaned from other periodicals and from the American Medical Association Department of Communications.

****A U.S. Court of Appeals** has held that fiduciary duties under ERISA require HMOs to disclose physician financial incentives that discourage referrals to specialists. In Shea v. Eisenstein, the patient's estate alleged that the patient, a 40-year-old man, did not receive a referral from his primary care physician to a cardiologist, despite being hospitalized for chest pain on an overseas trip, and despite providing the physician his extensive family history of heart disease. The patient died a few months later. The Eighth Circuit held that the behind-the-scenes efforts to curb specialist referrals violated the HMO's fiduciary duty under ERISA. The court held that 'a financial scheme put in place to influence a treatment doctor's referral practices when the patient needs specialized care is certainly a material piece of information.' *(**BNA's Managed Care Reporter**, March 5, 1997)*

****MedPartners** continues to make news, with the recent announcement of a 10-year strategic partnership agreement with Aetna/U.S. Healthcare. Under the agreement, MedPartners will acquire Aetna's physician practice management business and 47 family medical centers which employ 189 physicians. MedPartners has agreed to serve Aetna's HMO enrollees in any market on a capitated basis, except where MedPartners lacks a complete network. Analysts believe that the partnership will allow both entities to expand their geographical presence. *(**Modern Healthcare,** March 10, 1997)*

****A recent Government Accounting Office** report found that three of the largest insurance carriers in the Federal Employees Health Benefits Program estimate that using pharmacy benefit management companies saved them over $600 million in 1995. The savings came from both manufacturer and pharmacy discounts and drug utilization management and reduced what each plan would have otherwise paid by 20 percent to 70 percent. *(**BNA's Managed Care Reporter,** March 12, 1997)*

Free Information Hotline for Medical Practice and Laboratory Services

COLA, the international healthcare accreditation body, announced the launch of its Information Resource Center which features a toll-free telephone number for information relating to medical practice and laboratory programs and services. The number is **800-981-9883.**

Detailed information that can be received through this new service includes:

- accreditation programs for medical laboratories;
- achievement programs for Waived/PPM laboratories;
- medical office achievement including facility review, medical record review and credentialing; and
- CLIA fact sheets--easy-to-understand explanations of laboratory regulations.

Technical inquiries and customer support are still handled by COLA's Customer Service Center at 800-298-8044.

COLA is a nonprofit, physician-directed organization whose purpose is to promote quality and excellence in medicine and patient care through a program of voluntary education, achievement and accreditation.

For more information about COLA, call 800-981-9883.

Correction



Dr. Jeremy Lazarus of Arapahoe Medical Society (not Clear Creek Valley, as reported last month) was elected to fill the remainder of the Alternate Delegate term of Dr. Joel Karlin of Clear Creek Valley.

Dr. Rohrer Retires

After 14 years as Executive Director of the Tri-County Health Department, Hugh Rohrer, MD, is retiring. Dr. Rohrer says he will leave



Hugh Rohrer, MD, Executive Director, Tri-County Health Department

his post on May 30.

Even with the monumental growth seen in the tri-county area (over 27 percent since 1983), Dr. Rohrer ably led the department in its efforts to provide public health programs to Douglas, Adams and Aurora counties. A national search for his replacement concluded on April 15.

Dr. Rohrer has no immediate plans, but does intend to remain involved with public health.

Dr. Gabow honored as distinguished internist

Patricia Gabow, MD, FACP, CEO and medical director of Denver Health, was recently honored by the Colorado Chapter of the American College of Physicians as one of two 1997 recipients of the Distinguished Internist Award.

The Distinguished Internist Award honors Fellows and Masters of the Colorado Chapter of the American College of Physicians who have demonstrated by their example and conduct an abiding commitment to excellence in patient care, education or research, and who have made special contributions of service to their communities.

Dr. Gabow is a natioanlly prominent physician, educator and clinical investigator in nephrology.



Dr. Gabow, 1997 recipient of the Distinguished Internist Award.

She has been instrumental in guiding the transfer of Denver Health from city government to an independent governmental authority. She has been sole manager and CEO of Denver Health since 1995.

Medical delegation to China

Drs. Kathleen Wood and Robert Buchanan will lead a delegation of physicians on a trip to China. Seen as a way to improve knowledge of "traditional methods" , learn more about Chinese culture and exchange ideas with Chinese doctors, the group will visit several cities located throughout China. The trip is planned for this fall.

Conference to address the future of health care

A prestigious panel of health care experts will present their views on *Health Care in the 21st Century: What Challenges Lie Ahead* at the Seventeenth Annual Montgomery Dorsey Symposium, scheduled July 24-26, at the Vail Cascade Hotel & Club, Vail, Colorado.

Keynote speakers will include Victor Fuchs, Ph.D., Henry J. Kaiser Jr., Uwe Reinhardt, Ph.D., and Reed Tuckson, M.D. John Iglehart, editor of *Health Affairs*, will moderate the conference.

The Symposium is sponsored by HealthONE in Denver and provides the opportunity for professionals from health care to participate in a dynamic forum with leading industry experts. For more information, call (303) 322-3515.

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◆ *PROFESSIONAL OPPORTUNITIES*

WANTED: Part time family practitioner or GP for multispecialty group 2-3 days a week. One year commitment. Hourly or salary position. Please call (303) 508-6478 and leave a message. 03/0397

ASPEN: Well established internal medicine practice seeking **Internist-Gastroenterologist** to join three physician practice. Please fax C.V. to 970-920-2282 or call Christine at 970-925-5440 M-F, 9-5. 03/0497

BOULDER – Excellent opportunity for Board Certified MD in Urgent/Family/Occupational care. Reply to Medical Director, Meadows Medical Center, P.C., 4800 Baseline, D-106, Boulder, CO 80303-2643. (303) 499-4800. 04/0597

GERIATRICS– Established practice needs additional physicians to provide medical care to patients in long term care facilities. Currently serving over 1800 residents in 62 nursing homes throughout the Denver area. The Geriatric Medical Clinic is committed to offering exceptional, quality health care coverage to our patients. If interested, please send CV to Terry Jorba, Geriatric Medical Clinic, 901 W. 14th Ave., Denver, CO 80204, or fax to (303) 595-9132. 01/0597

FT.LUPTON/KEENESBURG, COLORADO Dynamic family practitioner needed to join a rural team of one FP and two FNPs. Physicina wil practice at the Ft. Lupton Clinic on alternative days (20 minutes apart). Call will be 1 in 4.

Physician will be employed by large hospital located 30 miles north. Full benefits package including salary, incentive plan, CME's, health, dental, etc. These rural communities are located one half hour northeast of Denver.

Send CV to: Sherry Kozero-Roth, Physician Services, 1801 16th Street, Greeley, CO 80631; Phone (970) 350-6786. 03/0597

GERIATRICIAN-PACE site in Denver looking for innovative physician to join growing program for the frail elderly. Strong multidisciplinary team, small organization allows freedom practice to obtain goal of maintaining the elderly at home instead of nursing homes. BC, FP or IM. CAQ in Geriatrics. Fellowship a plus but not necessary. Competitive salary; great Rocky Mtn lifestyle. Contact Willie Orr, Total Longterm Care, 3204 W. Colfax Ave., Denver, CO 80204 or call (303) 573-8123. 03/0497

STERLING, COLORADO – Rural Northeast community is seeking BE/BC family practitioner with OB skills to join a busy family practice group in a new, attractive, and fully equipped building adjacent to a 36 be regional medical center. The departure of a physician has created an opening and the cnadidate will assume a full load of patients. Currently two physicians and two FNPs staff the practice.

Physician will be employed and will receive a competitive salary with an incentive plan. Full benefit package including CME's and moving expenses.

Sterling Regional Medical Center's medical staff consists of 30 physicians, a number of midwives, and serves a population of 25,00. It is located 2 hours northeast of Denver and offers hunting, boating fishing, and a golf course.

Send CV to: Jan Mesar, PO Box 830, Loveland, CO 80539-0830: Phone (970) 635-4036. 03/0597

◆ *SITUATIONS WANTED*

NEW PA GRADUATE OF U OF IOWA SEEKING FT employment in FP, ER/Urgent Care in Colorado front range area. If you desire enthusiasm, flexibility and strong interpersonal skills, contact **Carlie Deike** at (319) 354-7647. 04/0597

◆ *SITUATIONS WANTED*

FEMALE PHYSICIAN with 20 years experience in office GYN, family planning and low-risk prenatal care seeks part-time position in Denver metro area. M. Mack, MD (303) 337-4399 or 851-0429. 03/0397

◆ *PROPERTIES FOR SALE OR LEASE*

MEDICAL BUILDING–LEASE OR SALE: Great Lakewood Loc. 2700 Sq. Ft.: 4 Exams, 3 labs, 2 offices + amenities. Move-in condition professionally finished. Call Joan at Beldock & Assoc. Metro Brokers 399-2566. 03/0597

◆ *SERVICES*

LOCAL LOCUMS is a Denver-based medical practice dedicated to providing quality locums coverage to Colorado family doctors. If you need to be away from your office or want to expand your practice without the risk and expense of hiring a new partner, we'd be happy to talk to you about how we can help. Please call Dr. Sheldon or Dr. Sowell for more information at (303) 370-6977. 06/0497

ANNOUNCING A BREAKTHROUGH technology for early detection of coronary disease!! Introducing region's only coronary artery disease risk assessment center featuring **the revolutionary ultrafast CT scanner®.** Non-invasive, fast, inexpensive, extremely sensitive, specific for coronary plaque. Much more powerful than traditional risk analysis for prediction of coronary events (circulation, 6/96). A negative stress test is common in patients before a major heart attack. Used by prestigious university preventive cardiology centers (Mayo, UCLA, Baylor, Penn) to determine risk reduction strategies. **Colorado Heart Imaging** opens April 1997 at the Denver Medical Imaging Center, 2490 W. 26th Ave. Scans interpreted by staff radiologists and cardiologists. For patient referrals or information, call 303-433-8800 or 800-800-3943. 11/0397

◆ *SERVICES*

MEDICODE MEDICAL BILLING SERVICE is looking to develop a long term, mutually beneficial relationship with a few good Doctors. We have six years experience serving Medical Offices in the Denver area with accurate and timely billing. We offer lower rates, for filing claims in Management, Accounting and acquiring Insurance Credentials. You've tried the rest, now try the best. Contact Cecilia Fox at Office Phone 303-255-1512 Fax 303-280-5343.

◆ *MISCELLANEOUS*

RETIRING? MERGING? RELOCATING? PROJECT CURE WILL PICK UP YOUR SURPLUS MEDICAL EQUIPMENT, SUPPLIES AND BOOKS TO RECYCLE TO THIRD WORLD COUNTRIES. CALL JIM JACKSON AT 727-9414 OR FAX 674-9790.
11/0197

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A Unique Fringe Benefit For CMS Members



Buying or Leasing a New Car???

The **Colorado Medical Society** now provides a professional fleet management service to assist members throughout the state when purchasing or leasing a new vehicle. This service provides valuable vehicle information such as factory invoice costs, available options, technical data, consumer reports, etc.

Once your selection is firm, your purchase or lease will be arranged at **prices normally available only to large corporate fleets**.

Colorado Medical Society has endorsed Rocky Mountain Fleet Associates as a CMS member service, based on the satisfaction of the many physicians who have used their services over the past several years. These physicians have reported excellent results, **usually with savings of more than $1000 from even the best negotiated showroom price**.

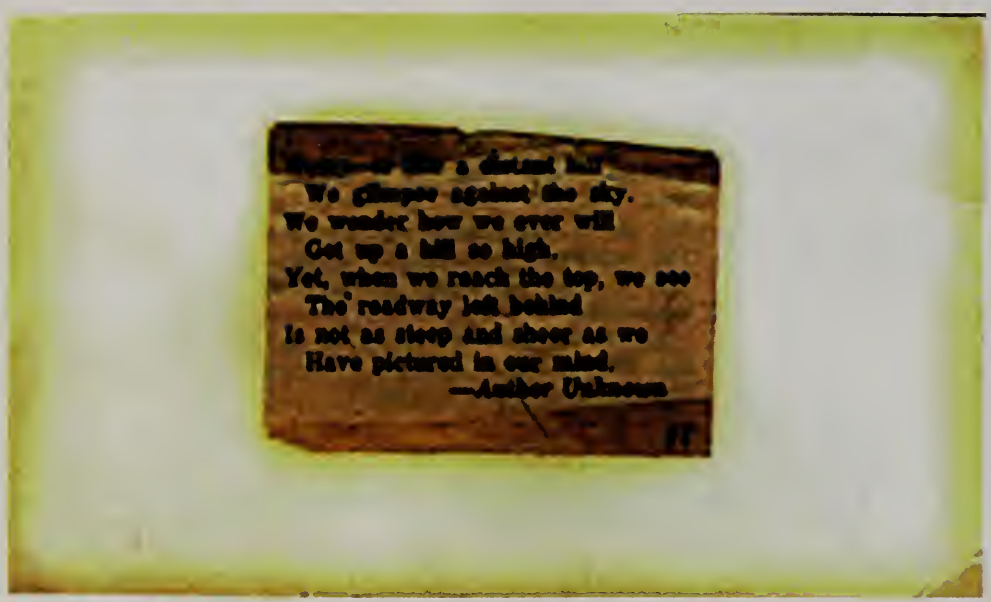
For more details, call **(800) 864-4388**. In Denver, **753-0440**.

Colorado Medical Society

RUMINATIONS

(**def:** chewing again what has been chewed slightly and swallowed; to **REFLECT**)

*by **Bill Pierson**, Managing Editor*



This is wierd! It was April 20,1997, of an evening; I was sitting at my office desk at home. While I performed relatively mindless labor I listened to one of my favorite compact discs of Celtic music. It's what some might call good "elevator music" but I like it because it brings to mind many of the scenes of Ireland.

Under the glass on my desk I keep (and have kept for years) a lot of little personal things, pictures, notes of particular sentiment, some verse, and some quotations even.

Just as the third piece on the CD began, my eye travelled to this yellowed card on which someone years ago had taped a verse clipped from a magazine. I found the card with the verse lying on a window sill on the 14th floor of the vacant (except for me) Daniels & Fisher Tower at 16th and Arapahoe. I noticed the card lying there as I climbed the stairs (one of the hundreds of trips I made up those stairs because there was no other way to get to the top). The clipping reads:

Worry—is like a distant hill
We glimps against the sky.
We wonder how we ever will
Get up a hill so high.
Yet when we reach the top, we see
The roadway left behind
Is not as steep and sheer as we
Have pictured in our mind.
—Author Unknown

That was 33 years ago. I have to give you a little history: I was struggling at the time with my radio station, **KBPI**, located atop the tower. It was the year before I could even get the station on the air because of some of the most bizaare problems (about which I am writing a book).

I learned many years before not to worry unless worry caused you to take some action. Well, at that time I was beset with every kind of physical, financial, spiritual, familial, legal and material problem. When I saw this card and verse I knew I would keep it for the rest of my life. It said what I believed. I thought it was something I was meant to find. I can remember vividly when, faced with the very public problems of foreclosure on the building, threats against me by parties to liability suits, and everything else imaginable, I was often ready to give up. But I would always return to the "principle" side of things, demanding that I shouldn't be a victim of someone else's misdeeds. I had no other choice. I could think of only one thing to do, and that was go ahead with my original plans, which I believed were honorable and sensible. About the only alternatives were to lie down and get stepped on, or go to the top of the tower and jump the 360+ feet to the ground.

When that song started the other night, I just happened to look down at my desk and see this verse. I began to read it to myself, and quickly realized the verse fit the song... the music fit the iambics of the verse perfectly; what's more, the lines of the melody were the same length as the lines of the verse. It was absolutely eerie!

But that's not all. I listened to this song and even began to sing the words to the music, a number of times. Then, I had a thought: is it possible that the song can be further identified with the verse by its title. That would truly be something, I thought.

I looked at the album liner. The name of the song? ***"Spancil Hill."***

All of this **means something!** I haven't figured out just what, quite yet.

COLORADO MEDICINE

"Advocating excellence in the profession of medicine"

, 1997 Volume 94, Number

Orchestrating Community Health"...

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Composed and Conducted by Physicians

What part will you play?

127th Annual Meeting of the House of Delegates

Colorado Medical Society • September 12-14, 1997

Snowmass Conference Center • Snowmass, Colorado

Complete schedule-registration and related information in this issue.

Working in concert

Creating harmony



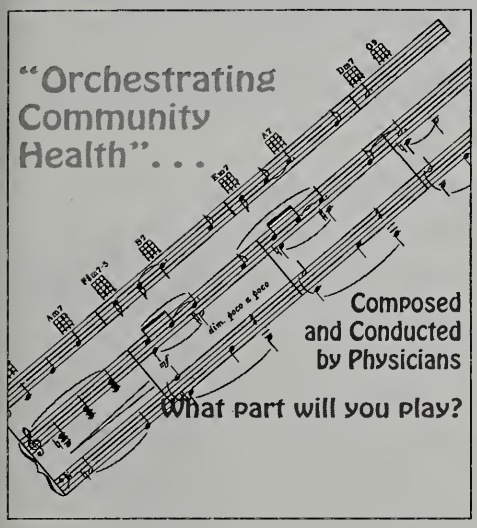
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COLORADO MEDICINE

June, 1997 Volume 94, Number 6



In This Issue...

The 127th Annual Meeting of the Colorado Medical Society will be held on September 12-14 at the Snowmass Resort and Conference Center. Plan on joining us to review the events of the past year, and set policies and plans which will guide the medical society in its endeavors during the rest of 1997 to 1998.



Returning to the popular Snowmass area, this year's meeting is packed full of events and activities to enhance your commitment to your patients. Rest assured that CMS has once again planned a top-notch meeting with a provocative educational program and other functions which will engage your professional spirit.

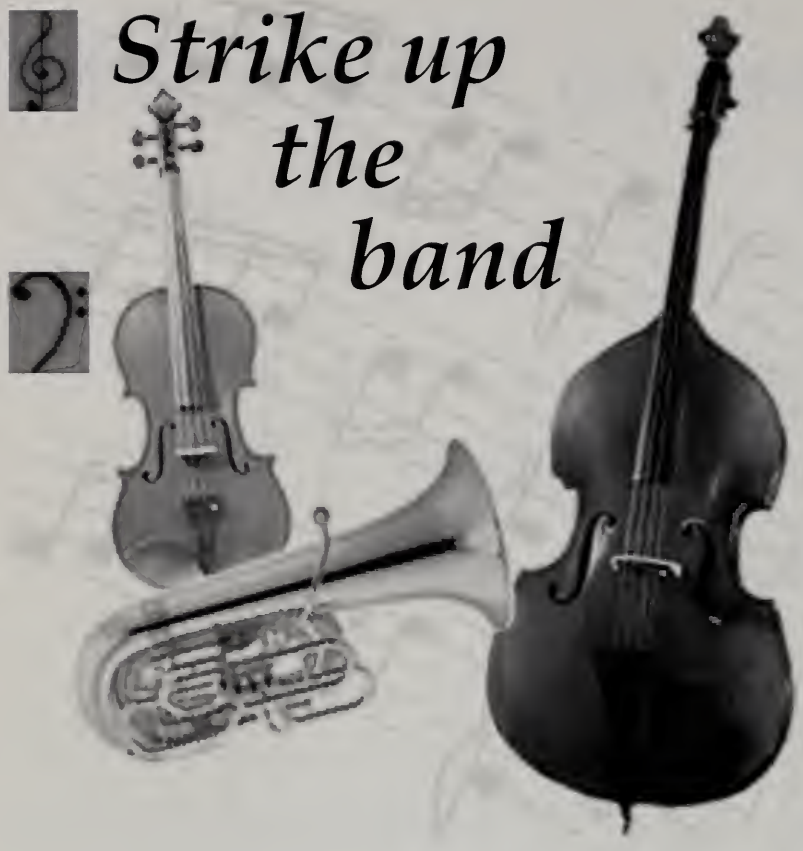
Boasting some of Colorado's most breath-taking scenic views, Snowmass provides the perfect setting to conduct business, visit with colleagues and enjoy a weekend getaway. Outdoor enthusiasts will have an almost unending choice of activities including golf, hiking, horseback riding, whitewater rafting, mountain biking and fishing. Others can sit back and relax in the peacefull surroundings of the Silvertree Hotel or drive the short distance to Aspen to shop at some of the Rocky Mountains most acclaimed stores. Whatever your preference, Snowmass Village and the surrounding areas offer enough to play to the most creative imagination.

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Sandra L. Maloney, Executive Editor; William S. Pierson, Managing Editor; Chet Seward, Communications Specialist

Member, Colorado Press Association, Member, Colorado Broadcasters Association



Join us at the welcome reception

Physicians as musicians and conductors? You bet! This is your formal invitation to the Thursday night welcome reception, September 12. A perfect opportunity to visit with friends before formal business begins, come help start the 127th Annual Meeting of the Colorado Medical off on the right note.

Live orchestral music will be provided by a gifted band of your colleagues. Hone your music skills with "name that tune" competitions. Whether you are a virtuoso, an amatuer, or even if you can't hold a tune, a host of other arrangements and activities will provide an enjoyable first act to the 1997 CMS Annual Meeting. The melodies and fun begin promptly at 6:00 p.m.

Activities available during the 1997 Annual Meeting

Golf–Both Aspen and Snowmass have 18 hole championship courses. The public Aspen Golf Course (7,165 yards, par 71) is spectacularly framed by a view of the Maroon Bells. The private Snowmass Club course (6,817) is similarly surrounded by high alpine peaks and offers bent grass tees and greens. At an altitude of 8,000 feet, golfing The Aspens offers a challenge to any experienced golfer.

Tennis–Two indoor and eleven outdoor courts at the Snowmass Club provide outstanding year-round tennis opportunities for guests. Private and group lessons, clinics, and tournaments are offered throughout the year by full time professionals.

Horseback riding–All day, half-day, and hourly wilderness trail rides are available to guests with or without a guide.

Hot air ballooning–For thrilling views of the Rocky Mountains' highest peaks, guests will enjoy the champagne breakfast balloon flights held in both Snowmass and Aspen - winter and summer.

Rafting–River rafting excursions are offered by a variety of companies. For calm scenic splendor or white water challenge, the adventurous can arrange daylong or overnight expeditions along the Roaring Fork, Colorado, Crystal, Gunnison and Arkansas Rivers.

Fly fishing–Between the Roaring Fork and the Frying Pan, some of Colorado's best fishing is within minutes of Aspen. Professional guides and equipment rental are available for the beginning angler as well the seasoned fly fisher.

Hiking–Aspen and Snowmass are uniquely situated among five nationally designated wilderness areas. Miles of trails are accessible to the hiker eager to scale some of the area's "fourteeners" (14,000 foot peaks) or simply seek out fields of high alpine wildflowers. Wilderness tours and naturalist-guided walks can be arranged.

Bicycling–Bicycle rentals and guided tours are offered by a number of shops in the area, and provide guests ample opportunity to explore back country roads and trails via mountain or road bike.

Colorado Medical Society
Annual Meeting Educational Program

Saturday, September 13, 1997

Snowmass Conference Center/Silvertree Hotel, Snowmass Village

"Orchestrating Community Health" – Composed and conducted by physicians. What role will you play?

This year's educational program will be directed by Joseph Bujak, MD, and Linde Howell. Both are well known health care experts. Dr. Bujak is also keynoting the opening session of the House of Delegates. Ms. Howell is currently Vice President of Janus Healthcare Consultants, Inc., a health care consulting firm specializing in strategic planning, community health assessment and improvement, community-wide disease management continuums, community partnerships, business development, and network design. She has developed a nationally recognized model for assessing and improving community health, as well as a model and training program for community health champions. She has been a national leader in the area of healthy communities, health promotion, and community-wide demand management.



Dr. Bujak



Linde Howell

"Orchestrating Community Health" will be an interactive program geared toward physicians and spouses that will promote discussion and learning. The program will be broken up into two sessions during which attendees will be encouraged to participate as they move through stations which analyze specific issues. Community health encompasses almost every facet of health care from public health to business and social issues. Be sure to bring your spouse, because building community involves everyone.

Leadership through service *(Session 1)*

Commitment to service is the very reason physicians entered the practice of medicine. In this session, we will learn strategies for developing a service oriented culture within your practice and your personal life and the professional and economic advantages of such.

Building a community health symphony with physicians as composers and conductors *(Session 2)*

The Healthy Community Movement has been initiated most often by hospitals nationwide. These initiatives have encouraged community organizations to enhance their assets within both the community and specific organizations in order for the two to plan, grow and change with synergy. In addition to creating health communities, the results include increased organizational and community participation, cooperation and communication. Learn how medical group initiated project and participation offer specific personal and professional advantages.

COLORADO MEDICAL SOCIETY
AND COLORADO MEDICAL SOCIETY ALLIANCE
1997 Annual Meeting Schedule

Snowmass Conference Center/Silvertree Hotel, Snowmass Village
September 12-14, 1997

THURSDAY, SEPT. 11

8:00 am-	CMS Office open
7:30 am-	18-hole Golf Tournament
1:00 pm- 2:00 pm	Finance Committee
2:00 pm- 5:00 pm	Board of Directors
4:30 pm- 8:00 pm	Registration open
6:00 pm- 7:30 pm	Welcome Reception
7:30 pm-	Dinner on your own

NOTE: Dress for Annual Meeting

Thursday evening reception ....
Friday: ..... casual
Saturday morning: ..... casual
Saturday inaugural dinner/dance: coat-tie/dressy business attire or cocktail dress
Sunday: ..... casual

FRIDAY, SEPT. 12

7:00 am--	CMS Office opens
7:00 am-- 5:00 pm	Registration
7:00 am-- 7:45 am	Reference Committee Breakfast
7:00 am-- 7:45 am	New Delegate Orientation Brkfst
7:00 am-- 7:45 am	AMA Delegation Forum Brkfst
8:00 am- 12:00 N	Exhibits open
7:45 am-- 8:00 am	Credentials Committee
8:00 am-- 8:30 am	Opening Session House of Delegates
8:30 am-- 9:30 am	Alliance Board Breakfast
8:30 am- 12:00 N	General Membership Meeting
9:30 am-- 9:45 am	Coffee break
9:45 am- 11:45 am	Alliance General Meeting
12:15 pm- 1:45 pm	COMPAC/CMSA Luncheon
2:00 pm-- 3:00 pm	Alliance Workshop
2:15 pm-- 3:15 pm	Copic Risk Management
2:15 pm-- 3:15 pm	Copic Risk Management
2:30 pm-- 4:30 pm	Reference Committee
3:00 pm-- 4:30 pm	Alliance County Breakout Sessions
3:30 pm-- 5:30 pm	Reference Committee
3:45 pm-- 4:45 pm	Copic Risk Management
3:45 pm-- 4:45 pm	Copic Risk Management
4:00 pm-- 7:00 pm	Exhibits open
5:30 pm-- 7:00 pm	Exhibitor Reception
6:30 pm-- 8:00 pm	Women in Medicine Dinner and Business Meeting
6:30 pm-- 7:30 pm	Colorado Society of Internal Medicine Annual Meeting
7:00 pm-- 9:00 pm	Gone But Not Forgotten Dinner (by invitation only)

SATURDAY, SEPT. 13

7:00 am-	CMS Office opens
7:00 am- 11:00 am	Registration
7:30 am- 8:20 am	Prayer Breakfast
7:30 am- 8:20 am	Educational Program Continental Breakfast
7:00 am- 11:00 am	Exhibits open
8:30 am- 12:00 N	Educational Program
8:00 am- 12:00 N	Alliance Meeting
12:00 N-	Recreation Time - golf, tennis, horseback riding, biking, fishing, walking, etc.
1:00 pm- 3:00 pm	Drug Formulary Forum
1:00 pm- 4:00 pm	Copic Seminar
5:30 pm- 6:15 pm	Cocktails - cash bar
6:15 pm- 7:00 pm	Inaugural
7:00 pm- 10:30 pm	Presidents' Dinner/Dance
9:00 pm- 10:30 pm	Copic Dessert Reception

SUNDAY, SEPT. 14

6:30 am-	Reference Committee Reports available
7:00 am-	CMS Office opens
7:00 am- 10:00 am	Registration
7:00 am- 8:30 am	Component Caucuses Arapahoe Aurora-Adams Boulder Clear Creek Valley Denver El Paso Larimer/Weld Pueblo/Western Slope
8:00 am- 8:30 am	Credentials Committee
8:30 am- 12:00 N	Closing Session HOD
9:00 am- 10:00 am	CMSA Gavel Club Breakfast
12:00 N (or immediately following HOD)	Reorganizational Board Meeting

Joseph Bujak, MD, FACP, to keynote Annual Meeting



Renowned health care futurist, Joseph Bujak, MD, FACP, will be the keynote speaker at the 1997 Annual Meeting of the Colorado Medical Society. Dr. Bujak will focus on the major dynamics transforming the health care industry and how they are impacting physicians. He will critically assess the way physicians currently approach patient care, and examine the factors that cause an absence of health in populations. What's at stake for you as the tactical forces of health care continue to change, what is your business, and what is it that you value both professionally and personally? Difficult questions and challenging answers will be explored as Dr. Bujak engages you in determining if there is a better way.

Dr. Bujak currently serves as Vice President, Medical Affairs for Kootenai Medical Center, Coeur d'Alene, Idaho, and VHA's Mountain States region. A dynamic speaker, he understands the stabilizing role of positive vision and strongly held values, and works toward developing leadership and followership, especially in the physician community.

CMS Annual Meeting Golf Tournament

at the Snowmass Club Golf Course
Thursday, September 11, 1997
Entry Form

Name _____

Address _____

Please give us the following information for tee times and emergencies

Office Phone _____ Home Phone _____ FAX# _____
(necessary for reservations)

While in Snowmass I will be staying at _____

I will be attending the meeting in the capacity of (check one)

❑ Physician ❑ Exhibitor ❑ Spouse ❑ Other

I will: ❑ Sponsor a golf course hole @$100 ❑ Sponsor a putting green contest hole @$50

Name of sponsor (as you wish it to appear on sign) _____
(Professionally made signs will be displayed for sponsors.)

My golf handicap is _____ or my average score is _____

Please reserve a set of ❑ **Left handed** ❑ **Right handed** clubs for me. I will pay the $30 rental fee on site.

If you would like to play please return this entry form as soon as possible because space is limited. ***CMS has reserved tee times, starting at 7:30 a.m. for only eight foursomes.*** Play will be scramble format. Foursomes will be arranged according to various levels of ability by the golf professional. If you have a preference of who you are teamed with, please specify below. Prizes will be awarded for a variety of categories to include closest to the pin and longest drive. To ensure tournament entry, registration form and advance payment of $95 must be received **no later than** August 21, 1997. Cancellations received after August 21, 1997 are refundable subject to ability of Snowmass Golf Club to "resell" vacated tee times.

You will be notified regarding tee times. A shotgun start will not be possible, therefore, please be prompt with your tee times. To reserve other personal tee times, please call the Pro Shop at (970) 923-5600.

I prefer to be teamed with _____

* Mail Entry Form and check to Barbara Campbell, 2251 Ash Street, Denver, CO 80207. For additional information please call Barbara Campbell at (303) 383-5307

Colorado Medical Society
Annual Meeting
September 12-14, 1997

Snowmass Resort Association
P.O. Box 5566
Snowmass Village, CO 81615
Phone (970) 923-2010
1-800-598-2004 FAX (970) 923-4260

If reservations have already been made directly with the hotel, please do not send this card. To make reservations by mail, please complete the following and mail to the address above. To guarantee these special rates, ***reservations must be received by August 28, 1997.***

Name _____

Name(s) of additional person(s) sharing room: (# of adults _____ # of children _____)

_____

Address _____

City _____ State _____ Zip _____ Phone ( ) _____

Arrival date _____ Departure date _____

Please reserve the following: (Special rates apply from September 9-17.)

❑ **Silvertree Hotel Lodge Room** ($113 per night for 2 persons, each additional $25)

❑ **Wildwood Lodge Room** ($100 per night for 2 persons, each additional $25)

Payment type–Personal check or major credit card may be used to secure deposit. One night's lodging required.

Silvertree Dbl.	**$113 + tax**
Wildwood Dbl.	**$100 + tax**
Check-in Time:	**4:00 pm**
Check-out Time:	**11:00 am**

Type of card _____

Card # _____ Exp. Date _____

Name of Cardholder _____

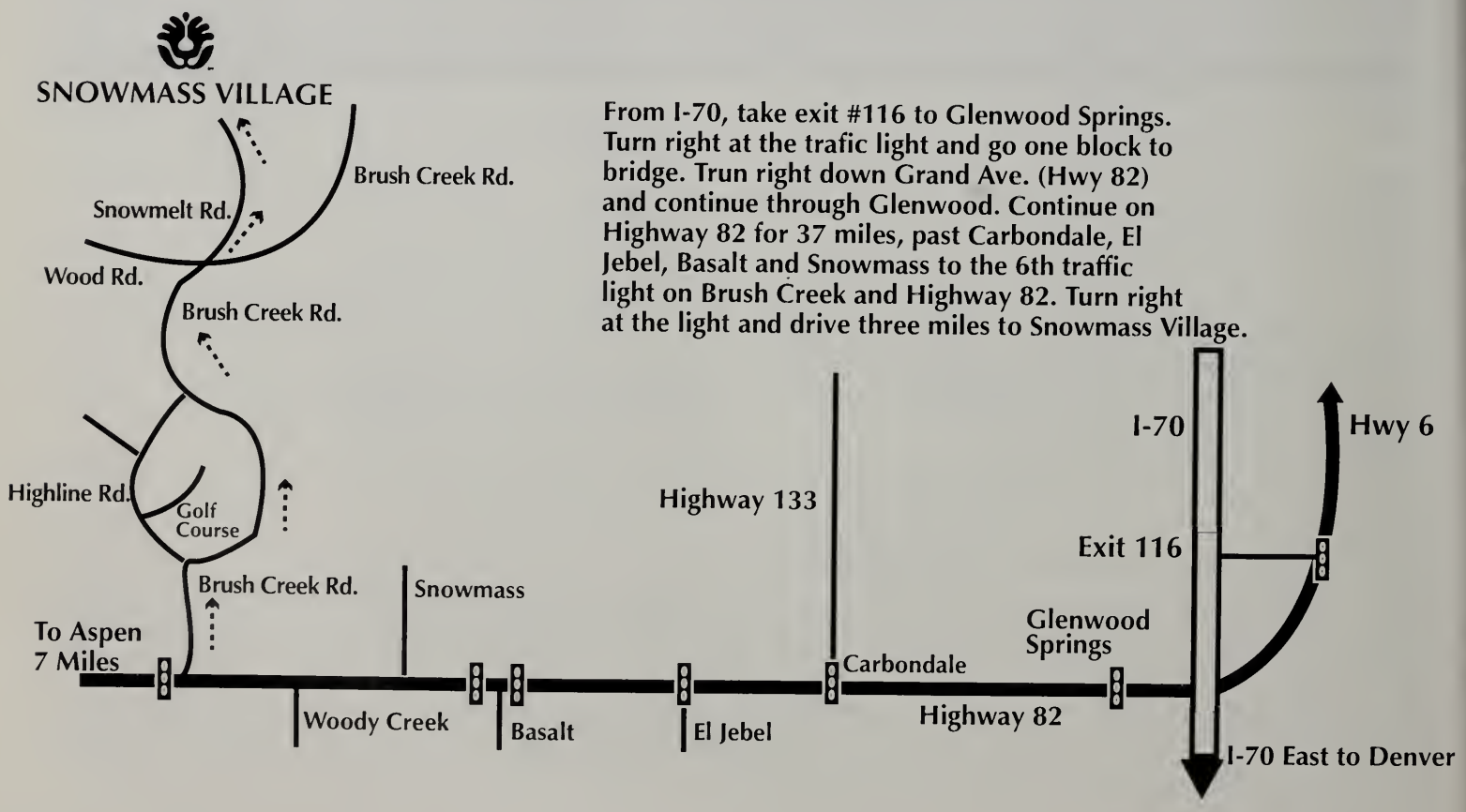
"I authorize Snowmass Central Reservations to charge my credit card for the deposit and prepayment for accommodations listed above."

Signature _____ Date _____

Children 12 and under stay for free in parent's room with existing bedding. Current sales tax is 11.5% (subject to change). CANCELLATION POLICY: If cancellation occurs 14 days or more prior to arriaval, there is a 10% handling fee. If cancellation occurs less than 14 days prior to arrival, deposit is forfeited unless room is re-rented. If re-rented, full refund will be made, less 10% handling fee.

Please let us know how we may accommodate any disability or special request.

GETTING TO SNOWMASS VILLAGE



From I-70, take exit #116 to Glenwood Springs. Turn right at the trafic light and go one block to bridge. Trun right down Grand Ave. (Hwy 82) and continue through Glenwood. Continue on Highway 82 for 37 miles, past Carbondale, El Jebel, Basalt and Snowmass to the 6th traffic light on Brush Creek and Highway 82. Turn right at the light and drive three miles to Snowmass Village.

Annual Meeting Registration

1997 Annual Meeting of the Colorado Medical Society and CMS Alliance
September 12-14, 1997, Snowmass Conference Center, Snowmass Village, Colorado

Name (please print) _____

Component Society _____ Names of Spouse/Guest(s) (if attending) _____

If you are not a member of CMS, please provide the following:

Company/Organization _____ Title _____

Reservations for Events and Meetings

Reservation deadline is August 29, 1997. (Note: To attend the President's Dinner Dance on Saturday, you **must obtain** your tickets before noon, Friday, Sept. 12.) Reservations accepted on a first-come, first-served basis (may be limited for some programs). For purposes of registration, staff of county medical societies are considered members. You must indicate the number of attendees for each function so that we may be cost efficient with food/beverage orders.

As a member, ***you and one guest are entitled to attend the complimentary events at no charge.*** Please indicate the number of additional guests at the bottom of this form and enclose your check.

Complimentary events open to all members: Please indicate below which functions you will attend.

THURSDAY, SEPTEMBER 11

6:00 pm	Welcome Reception	member ❑	guest ❑

FRIDAY, SEPTEMBER 12

7:00 am	New Delegate Orientation Breakfast	member ❑	
7:00 am	AMA Delegation Forum Breakfast	member ❑	
7:00 am	Reference Committee Member Breakfast	member ❑	
5:30 pm	Exhibitor Reception	member ❑	guest ❑

SATURDAY, SEPTEMBER 13

7:00 am	Educational Program Continental Breakfast	member ❑	guest ❑
8:00 am	Educational Program	member ❑	guest ❑
12:15 pm	COMPAC/CMSA Luncheon	member ❑	guest ❑
7:00 pm	President's Dinner Dance:		
	(Please select menu from below)		
	Beef and Chicken Dinner	member ❑	guest ❑
	Vegetarian Dinner	member ❑	guest ❑
	Vegan Dinner	member ❑	guest ❑
9:00 pm	Copic Dessert Reception	member ❑	guest ❑

Additional Reservations (other than member + 1 guest):

Educational Program Breakfast # _____ @$15 each= _____

President's Dinner Dance (**Reservations necessary**, please select menu below)

Beef and Chicken Dinner # _____ @$50 each= _____

Vegetarian Dinner # _____ @$50 each= _____

Vegan Dinner # _____ @$50 each= _____

..... Total for Additional Reservations $ _____

Non-Complimentary Events:

		Cost	Number
FRIDAY, SEPTEMBER 12			
12:15 pm	COMPAC/CMSA Luncheon	$20 each	_____
	..... Total for Non-Complimentary Reservations		$ _____

Total enclosed for non-complimentary and/or additional reservations ..... $ _____

After completing this form, please mail it to: CMS, P.O. Box 17550, Denver, CO 80217-0550, or FAX it to CMS at (303) 771-8657. For questions, please call (303) 779-5455 or 1-800-654-5653 ext. 2419.

OCCUPATIONAL MEDICINE PHYSICIAN

Wanted for long term commitment. Busy, thriving midtown state of the art occupational health clinic. This could be fee for service or salaried. Wonderful opportunity for motivated M.D. One opening is immediately available.

Please call Martin Shure,M.D., Medical Director, Midtown Occupational Health Services (MOHS) at (303) 831-9393 or fax C.V. to MOHS at (303) 831-6335.

Striking the right note: Composing financial strategies for the ever changing health care environment

A seminar sponsored by CMS and Copic Insurance, Saturday, September 13, 1997

This presentation will address issues regarding: practice valuation, choice of entity, governance/financial structure, compensation/income division, entry & exit planning, why deferred compensation?, asset protection planning strategies, business, personal, the Colorado managed care environment, marketplace challenge & opportunity, informed consent: MSOs, PPNs, etc., legal/business issues/ and mergers/acquisitions.

Leon B. Harrison, CLU, Copic, and Gerald Niederman, Faegre & Benson LLP will be the featured speakers.

Prayer Breakfast

John M. Perkins will be the featured speaker at the prayer breakfast Saturday morning, September 13, at 7:30 am. Absent from the annual meeting program lineup for a couple of years, the prayer breakfast will be revived by Mr. Perkins.

Founder of numerous Christian ministries, schools and other programs, Mr. Perkins engages audiences with passionate stories about personal experiences. His discussions focus on the need for leadership and community development.

Despite dropping out of school in the third grade, Perkins has been recognized for his work with five honorary doctorates. He is also the author of numerous books and is internationally known for his commitment to the impoverished and underserved.

Please plan on attending this provocative event before the Educational program.

Your CMS Board of Directors encourages you to participate in this year's annual meeting.

M. Ray Painter, MD, President
Gary D. VanderArk, MD, President-elect
George W. Shanks, MD, Treasurer
Ted T. Lewis, MD, Speaker of the House
Louise L. McDonald, MD, Vice-Speaker
Joel M. Karlin, MD, Past-president
Stephen G. Batuello, MD
Jack L. Berry, MD
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John O. Cletcher Jr., MD
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1997

Volume 94, Number 7

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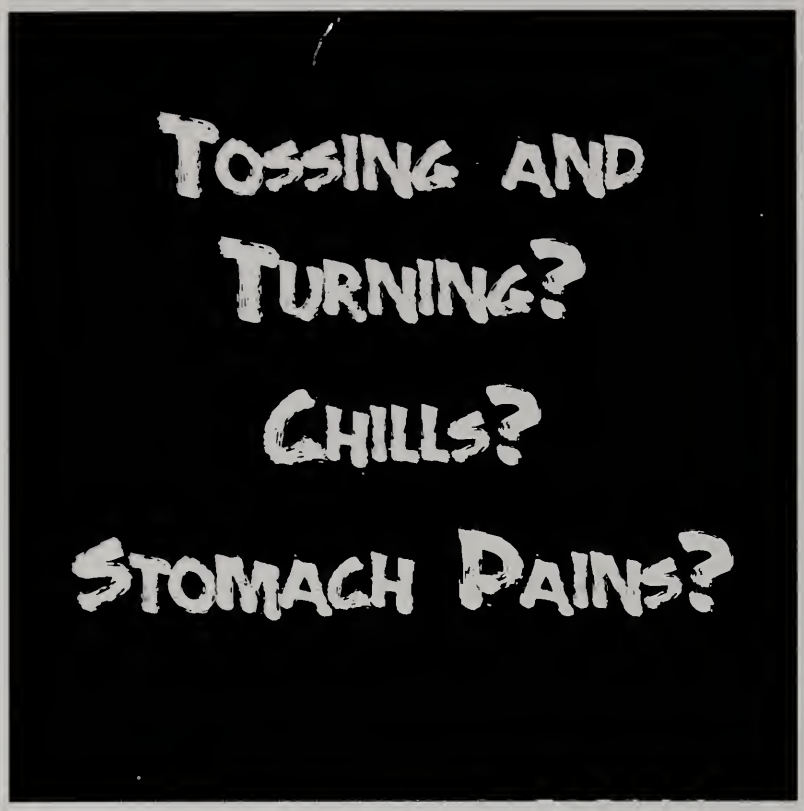
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"Traditional" vs **"Virtual"** Medicine: Shall we slay the *Dragon of Change*?

In This Issue:

Bucking the "trend in motion" revolution by M. Ray Painter, MD ..... **page 233**
Long range planning by Barbara R. Reed, MD ..... **page 242**
The integration of alternative and mainstream medicine, a model ..... **page 252**
High plains country physician ..... **page 262**



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COLORADO MEDICINE

July, 1997 Volume 94, Number 7



Cover Story

The line in the sand has been drawn....or has it? Traditional and virtual medicine square off in a duel facing many physicians today. See page 244.

Departments

233 President's Letter
235 Colorado Physician Network
236 Board Highlights
243 Colorado Medical Society Alliance
251 Copic Comment
256 Health Care Financing
258 New Members
262 Archives
266 Medical News
268 Classifieds
270 Ruminations

In This Issue...

233 **Stoking the revolution** -- many positive changes are being made by physicians and patients to reform the current health care system. This is no time to rest on physician laurels.

M. Ray Painter, MD
President, Colorado Medical Soceity

238 **Report to the Board -** Leigh Truitt, MD, Managed Care Consultant to the Colorado Medical Society, updates his current activities.

240 **CROP ploughs ahead** with development and program design plans. Learn more about the latest advances in the medical society's bold program to boost the numbers of rural health care providers in Colorado.

241 **CME and the evolving sytem of accreditation** -- new accreditation standards have been set.

242 **Long range planning** – a newly formed committee is hard at work to help shape the future of the Colorado Medical Society.

Barbara R. Reed, MD

246-249 Annual Meeting Registration

252 **Medical acupuncture:** a model of integrated health care from alternative to mainstream medicine.

Bryan L. Frank, MD

256 **Medicare fraud and abuse** -- clarifications in the carrier's role and the impact of recently enacted abuse statutes and sanctions.

264 **Off to new adventures** – after more than a decade of service to Colorado, Dr. Robert Bogin is moving.

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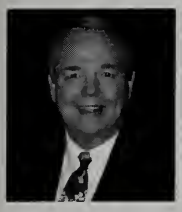
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Sandra L. Maloney, Executive Editor; William S. Pierson, Managing Editor; Chet Seward, Administrative Asst.

Member, Colorado Press Association, Member, Colorado Broadcasters Association

President's Letter



M. Ray Painter, MD
President, 1996-1997

Patients are beginning to exercise their clout in the marketplace, and physicians are not far behind. In the October issue of ***Colorado Medicine,*** I discussed the revolution that is under way and how patients and physicians have not yet participated. The beneficiaries of the current movement have been the employers, the Government, and Wall Street. The two groups with the largest personal stake, patients and physicians, have been the two groups adversely affected and least involved in shaping the changes. Now, patients are beginning to say "Wait a minute!" With the help of physicians, they are beginning to correct some of the "wrongs" that have been created in the transition of health care to a free market enterprise.

The Problem - "Gloom and Doom"

In all of the ruckus over managed care contracts, physicians as employees, for-profit health maintenance organizations (HMOs), affiliation-disaffiliation of medical panelists, doctor incentives for money-saving treatment and for non-referrals to specialists... just where do the patients stand? Patients are concerned about fewer healthcare choices, the possibility of being forced to change physicians, incentives for doctors not to treat, and the overall quality of care. They're tired of being offered "total" health care coverage, only to find out that coverage is being denied through pre-authorization—the "hassle" attached to obtaining pre-certification. They don't like it! Patients are starting to demand choice of physician, a decrease in the "hassle" factors, and coverage for "pre-existing" illnesses.

Managed care organizations (HMOs) have proven that they can drive down the cost of medical care. So what's wrong with the system?

First of all, it's a system that has taken a high road and a low road. The low road is a system driven by management, not by the medical needs of the people. Physicians no longer have patients; the managed care organizations have the patients and are the final authority on what will happen to each person's health care.

Doctors feel as though they have been cut out of the system: they're no longer the treatment decision-makers and, in many cases, they feel repudiated as creators of treatment protocol for patients. The majority of physicians have always been committed to advocating for their patients. Now, physicians find that in some instances they are prevented from discussing treatment options with the patient! In some settings, medical doctors can no longer consult with, or refer patients to, a specialist. Any incentive accepted by the physician for holding down costs of treatment, e.g., testing, etc., drives a wedge in the doctor-patient relationship and is cause of concern to all, including the government and the press.

Some physicians have been caught up in the "feeding frenzy" of covered lives, cost of care, etc. In fact, some of the oppressive delivery systems are run by physicians. The entrepreneur reaction of some of our

(Continued next page)

"It's time not only to join the revolution. It's time to lead it!"

(President's Letter continued)

colleagues has added fuel to the fires of suspicion.

It's Time to Join the Revolt - the Future is Bright!

It's time to join the revolution! The trend toward the high road, a high-quality health care system, has begun! In some managed care plans and in some locales, patients are receiving wider coverage, fewer denials, more choices, and higher quality care. In others, physicians have regained control of quality of care and the delivery of care. The emphasis is being based on evidence-based medicine, quality, and patient satisfaction.

The information technology revolution is allowing a greater sharing of more accurate information. Many HMOs are working to provide high quality, hassle-free care with an emphasis on patient and provider comfort and satisfaction.

We as a profession cannot condone the old and, in some cases, the current "trend in motion." There is much to be done. Many changes have to be made. We must continue to bend the trend in favor of the patient and quality care. We have a major role to play in this counter-revolution. We must continue to provide patients with education of the possibilities for care. We must provide leadership in directing society toward those possibilities, and organize ourselves to build the "managed care" system into a patient-friendly, high quality system that is cost efficient. Yes, it can be done. We are the only group that can develop that delivery system in partnership with the patient and managed care.

A high quality, cost efficient health care delivery system will be developed in select geographic areas. This is achievable in Colorado by a true partnership between patients, physicians, and the insurance/managed care industry, placing the emphasis, and therefore the incentives, on quality rather than cost/profit.

LEGAL UPDATE

from Gelt, Fleishman & Sterling P.C.



A. Craig Fleishman, Managing Director

Medical Practice Standards - Recordkeeping

In Colorado State Board of Medical Examiners v. Brian L. McCroskey, M.D. the Colorado Court of Appeals ruled recently that recordkeeping is, in fact and by law, an essential part of practicing medicine. The administrative law judge in McCroskey determined that "[t]he preparation of medical records is part of patient care and a standard of medical practice exists with regard to patient records. Medical records serve the purposes of continuity of care from on provider to another, peer review, the education of younger physicians, the continuing education of all physicians, protecting the legal rights of parents and their families and... determining cause of death".

In its decision, the Court of Appeals emphasized a 1989 amendment to the Medical Practice Act for the State of Colorado that further defined unprofessional conduct to include "[f]alsifying or repeatedly making incorrect essential entries or repeatedly failing to make essential entries on patient records". The Court further clarified that the standard of recordkeeping to which Colorado's medical professionals are held by the Medical Practice Act survives a patient's death.

For further information contact:
Gelt, Fleishman & Sterling P.C.
1600 Broadway, Suite 2600
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(303) 861-1000

CMS Med Fax®

...a compilation of medically-related news briefs of immediate interest to the physician community occurring after ***COLORADO MEDICINE*** has gone to press. ***AT PRESS TIME...***

CMS Med Fax®
by Montgomery Little and McGrew, P.C.
legal counsel to the Colorado Medical Society

The American medical community mourns the passing of James Todd, MD, surgeon and former Executive Vice President of the American Medical Association. Dr. Todd died on Tuesday, June 24th.

Dr. Todd was a most unusual person in the service of the medical profession; he served in a variety of positions with the AMA. As Dr. Nancy Dickey, Chair of the AMA Board of Trustees said, Dr. Todd "was an ardent spokesperson for the medical profession and a passionate advocate for patients. Through his visionary thinking and eloquent oratory, he elevated the medical profession's esteem of the AMA and established the AMA in the public arena as the national voice of medicine."

Dr. Todd was active in volunteer positions with the AMA from the mid-1970s, before joining the AMA staff in 1986. He led the AMA through some rough times and, as we remember him from this photo, always came through smiling. There was never any question but that Dr. Todd enjoyed immensely his role in the medical profession.



James Stiles Todd, MD
1931 - 1997

Revised Interprofessional Code now available

The Interprofessional Code is a publication which has been endorsed by the Colorado Bar Association, Denver Bar Association, Colorado Medical Society, and the Denver Medical Society.

This Second Edition contains recent modifications to the Federal and Colorado Rules of Civil Procedures and an update to the Colorado Code of Regulations as it pertains to release of medical records On October 1, 1996, the Department of Health approved an increase of the reasonable cost which may be charged for copying a patient's medical record and allows that actual postage costs may be charged. These items are not addressed in the Interprofessional Code, however. (See Karen Best's article on page 2 of MedFAX.).

The Interprofessional Code, Second Edition is now available for Colorado Medical Society members. Please contact Genni Pearman at 303-779-5455 ext. 2523 or 1-800-654-5653 or by fax 303-771-8657.

--- NOTICE---

Correction of Annual Meeting schedule
published in June, 1997 ***Colorado Medicine***

To all CMS members - The **Annual Meeting Registration** form and schedule of events incorrectly listed the COMPAC/CMSA Luncheon as taking place on Saturday, September 12th. The 1997 Annual Meeting Schedule **published in the June issue is correct.** The luncheon will be held **FRIDAY, September 11th, at 12:15 pm.**



Med Fax: Medico-Legal News

by Karen B. Best, Esq., an associate with the law firm of Montgomery Little & McGrew, P.C.

This column contains information concerning topics of general interest in the medical-legal field. For further information or help with specific problems, please contact Montgomery Little & McGrew, P.C.

The Revised Interprofessional Code answers frequently asked questions

The Interprofessional Code is not the law. It is better than the law. It's the product of untold hours of consideration by experienced professionals in the fields of medicine and law who got together and came up with guidelines that would work for both lawyers and doctors. While not a replacement for any law or rule of procedure, it attempts to apply those laws to everyday situations and to offer sound principals of behavior for professionals on both sides wondering what is expected of them in unfamiliar surroundings. This article attempts to answer some of the most frequently asked questions. The source is the Interprofessional Code, Second Edition, itself.

Should I be paid for time I spend meeting with the patient's attorney or the defendant's attorney?

Yes, you are entitled to fair and reasonable compensation for providing services in connection with litigation, including fees for time you spend in meetings with lawyers.

Before you agree to meet with a lawyer or provide any other services in connection with litigation, you should discuss fees, costs, and the scope of your retention up front with the lawyer and arrive at an agreement about the specific fees to be charged for the different services you agree to perform. Your fee rate may vary according to the service you will be performing; for example, research, review of documents, meetings, examination, depositions, travel and appearance at deposition or trial. If so, the specifics should be laid out and agreed upon in advance. The Code contains some useful tips about other issues that come up, such as cancellation policies and when you will be paid, as well as procedures to follow when you and the lawyer cannot agree on a fee and you are then subpoenaed to appear, involuntarily.

How much can I charge?

You won't find a number in the Code. The general rule is that you are entitled to "fair and reasonable compensation for providing expert testimony." The Code lists 8 factors to be considered in deciding how much to charge. These factors include the amount of time spent on review, preparation, drafting reports, travel and testimony; the degree of knowledge, learning or skill required; the amount of effort expended; the uniqueness of the expert's qualifications; current and reliable statistical income information of similarly situated experts; the amounts charged by similarly situated experts for similar services; the amount of other professional fees lost; and the impact, if any, on the expert's practice because of scheduling difficulties, other commitments, or other problems.

Be aware that there are some statutes, such as the workers' compensation statute, which set reasonable medical fee schedules which must be followed.

Can I meet privately with my patient's adversaries?

The Code provides that you cannot meet to discuss medical information privately with a patient's adversaries without the patient's attorney's prior knowledge of the time and place of the meeting, affording the patient's attorney the opportunity to object and be present at that meeting. Before you meet with an opposing attorney, ask to see an authorization signed by the patient allowing you to meet privately with the apposing attorney. You may refuse informal interviews altogether. The Code states that it is improper to disclose information not relevant to the same physical or mental condition at issue in the litigation, and that if there is any question about whether information remains privileged, the information should not be disclosed until the dispute is resolved by the parties or court. An exception may exist to the duty of confidentiality when a physician is sued by the patient, as to the condition and treatment at issue in the suit.

For years this has been a question hotly debated by attorneys involved in personal injury and medical malpractice litigation.

The Code follows the view taken by the Colorado Court of Appeals.

CMS Med Fax

Can I make my fee contingent on the outcome of the case?

No, never. Your compensation should never be conditioned upon or measured by the amount of the recovery received by the patient in the litigation. An agreement for a contingent fee would compromise the integrity of your testimony. Similarly, the lawyer cannot condition your compensation on the content of your testimony. This would be "clearly improper conduct" on the part of the lawyer,

Am I entitled to an expert witness fee if I testify as a treating physician?

Probably, but it depends. Generally, fact witnesses are not entitled to compensation over and above the standard witness and mileage fee. You are entitled to receive compensation as an expert when you testify to facts (such as your treatment of a patient) in a deposition or in court, so long as you came into possession of that information "solely because of your position as a professional person." Your position and status when you come into possession of relevant information determines whether you should be entitled to an expert witness fee. The federal courts in Colorado have ruled that treating physicians may not be considered expert witnesses unless they give expert opinions. As a matter of custom and practice in the area, treating physicians are paid for their time.

How much can I charge for copies of my patient records?

You may charge up to $12.00 for the first 10 pages and $0.25 per page thereafter, without approval from the Colorado Department of Public Health and Environment.

What is a "reasonable probability?"

The Interprofessional Code acknowledges the language barrier between lawyers and doctors, and places the burden upon the lawyer to educate the expert concerning legal standards of proof and the significance of technical legal terminology. "Reasonable probability" is: one of the most commonly used and most legally significant terms. To be competent, an expert's opinions should generally be based upon "reasonable probability."

"Reasonable probability" simply means that which is more probable than not, more likely than not, or over 50 percent probable. Opinions based upon surmise, speculation, or conjecture are irrelevant. An opinion need not, and should not, be based upon scientific or medical certainty, which is a far more stringent standard than the law requires.

When testifying as an expert, you should carefully distinguish between opinions you hold to a "reasonable probability" or "reasonable medical probability," from opinions you hold to a lesser degree, in which case terms such as "possible," "might," "may," "could," "guess," "maybe," and the like would be more accurate.

What can I do if a lawyer becomes abusive or attempts to intimidate me or to discourage my involvement in the litigation?

You need not tolerate abusive or improper conduct and should promptly bring it to the attention of the opposing counsel, the court or tribunal in which the action is pending, or an appropriate grievance committee.

The Interprofessional Code is available to members of the Colorado Medical Society. I recommend you obtain a copy.

CMS Med Fax

Colorado Medical Society provides the following listings of events as a member service only. Some events are approved for Continuing Medical Education credits. Information is provided by the sponsoring organizations. For more details, use the telephone contact at the end of the listing.

American Cancer Society
9th Annual Oncology Conference
July 18, 1997
Colorado Springs, Colorado
Contact: Jan Hodge (719) 365-5675

The Given Biomedical Institute
Genetics Ethics in the 21st Century
July 18-20, 1997
Aspen, Colorado
Contact: Linda Woodstock at (303) 372-9050 or 1-800-882-9153

Colorado Society of Osteopathic Medicine
Annual Meeting
July 25-27, 1997
Vail, Colorado
18 hours AOA category 1-A CME and Physician Asst Crdt.
Contact: Patricia Ellis at (303) 322-1752

America College of Cardiology
11th Annual Echocardographic Symposium on 2-D and Doppler Echocardiography at Vail
July 27-31, 1997
Vail, Colorado
27.5 Category 1 AMA CME credit
1-800-253-4636, ext. 695

International Skeletal Society
The International Skeletal Society 24th Annual Refresher Course
September 10-13, 1997
Santa Fe, New Mexico
(770) 641-9773

American College of Cardiology
14th Annual Santa Fe Colloquium on Cardiovascular Therapy
September 25-27, 1997
Santa Fe, New Mexico
17 Category 1 AMA CME credits
1-800-253-4636, ext. 695

Colorado Hospital Association
Accreditation Standards for Patient and Family Educ.
October 24, 1997
Englewood, Colorado
(303) 758-1630

American Lung Association
17th Annual big Sky Pulmonary & Critical Care Medicine Conference
March 25-28, 1998
Big Sky Montana
(406) 442-6556

First Colorado Electronic Data Interchange (EDI) Conference for physicians and office managers

Leading Colorado healthcare payers and electronic data interchange (EDI) and billing companies are jointly sponsoring "Healthcare EDI Colorado – Into the Next Millennium." The conference will be held on Thursday, August 28, 1997, at the Colorado Convention Center in Denver from 9:00 am until 3:30 pm.

The purpose of the one-day conference is to focus attention on existing and cutting-edge products, services, and programs for healthcare providers to demonstrate ease of use and flexibility.

Participating sponsors in this conference are CIGNA Healthcare, Clinic Services, Electronic Data Submission Systems (EDSS), Mountain Medical Affiliates (MMA), Paramount Health Services (physician-owned network), QualMed/Foundation Health Systems, Inc., and The Alliance.

Highlights of the program include:

- **Keynote address by Leland Kaiser, Ph.D.**
- **EDI panel presentation**
- **Break-out sessions**
- **Value-added informational exhibits (up to 35 separate industry exhibitors).**

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My Doctor Recommends RMPC



by David M. Martz, MD
President CPN

Marketing of Rocky Mountain Physicians Choice (RMPC) is off to a fast start in Cañon City, and there are three obvious reasons why.

First of all, over 90% of the physicians in the community have joined Colorado Physicians Network. Thus we have a very attractive provider panel to offer the employers: when they look at the list, they see immediately that there doctor is listed, and that they have abundant "choice" within the community.

Secondly, the physicians are enthusiastic about Rocky Mountain HMO/Physician's Choice and the plan's unique philosophy of health care. They are encouraging patients and employers they know professionally or socially to take a close look and consider one of the benefit packages for their families or employees. They are buying the coverage for their own employees: the strongest vote of confidence.

Thirdly, the RMPC staff is energetically contacting brokers and potential purchasers. They are orienting the physicians' office personnel, and responding to the individual input and feedback promptly.

Yes, the Cañon City medical community is a model to us all. In the image of the Western slope physicians over the past 23 years, they are embracing RMPC enthusiastically, and holding it up for all to see.

They recognize the necessity to "Make it Work", rather than to expect it to work. And we must learn from their example across the entire Front Range. Only as we all make this our own individual project can we anticipate success.

So, "hats off" to the Cañon City physicians. . . and "follow suit" to the rest of the Front Range medical community!

1997 Family Practice Opportunities Fair

September 5-6, 1997
Copper Mountain Resort

A relaxed, educational and fun setting to meet the state's second and third year Family practice Residents.

An opportunity to recruit well-trained, enthusiastic Family Practice Physicians and their families!

A recruitment even without the we" "they" environment. Exhibitors at the 1996 Opportunities Fair provided a consistent highly complimentary evaluation of the event.

More that 240 residents will be training in the state's Family Residencies during 1997/98. More than 80 Family Practice Residents will graduate in July, 1998.

For additional information contact: Commission on Family Medicine, 1180 Clermont, Denver, CO 80220. Or call (303) 315-9734.

This is an excellent opportunityto recruit Family Physicians for your practice site. Don't miss it!

Sandi Maloney is on vacation. Her column, "Executive Director's Update", will appear next month.

BOARD HIGHLIGHTS

HIGHLIGHTS OF BOARD OF DIRECTORS MEETING - May 30, 1997

CMSA: Officer installations: Stella Shanks, President; Sonia Unrein, Secretary; Patty Ackley, Treasurer. Ms. Shanks reported the Alliance Annual Meeting in April was snowed out, and the only members able to attend were those from Grand Junction. Stella will be attending the AMA Annual Meeting in Chicago, with Leslie Nathan and Sue Forestberg. She thanked CMS for the funding for their part-time secretarial position, filled by Donna Foss.

AMA Delegation:
Dr. Ray Painter presented the report in Dr. Quinn's absence. Dr. Robert Bogin, Alternate-Delegate, has resigned from the Colorado Delegation because he is moving to Philadelphia. Per our CMS Bylaws, Dr. Painter has appointed Dr. Gary VanderArk to take Dr. Bogin's place as Alternate-Delegate for the AMA Annual Meeting in June. An Alternate-Delegate will be elected at the CMS Annual Meeting in September. The Delegate Handbooks for the AMA Annual will be mailed on 5/31/97. Dr. Painter invited the Board to look at the handbook.

Colorado Physicians Network (CPN):
Dr. David Martz stated that CPN continues to make progress. David Gingsberg has been formally contracted as the Executive Director of CPN. Except for three counties, CPN has received Medicare approval in Colorado. CPN has withdrawn their Medicare application in those three counties. CPN continues to work with Medicaid to obtain approval. As of last month, CPN had 485 enrollees. Dr. Martz thanked Dr. Buglewicz for his support in the Canon City area.

Colorado Rural Outreach Program (CROP):
In Dr. Jack Berry's absence, Ms. Ellen Stein presented the update. CROP has hired a new resource development consultant, Mirenda & Associates and they have begun working on the fund raising campaign.. Mr. Ron Mirenda came highly recommended. The Board Members for the CMS Foundation have met to discuss what their role will be, basically that of overseeing and administering the funds for CROP. CMS will be exhibit CROP at the World Health Resource Center's Annual Meeting in Montrose.

Long Range Planning Committee (LRPC):
Dr. Ray Painter reported that the LRPC is working on revising the CMS Mission Statement, and creating a Vision Statement. He explained the composition of the LRPC. Discussion regarding language for the Vision Statement was held. Dr. Ted Lewis (House Speaker) felt that the Vision Statement should be expanded upon to include language such as "promote public health and the common good of the citizens of the state".

Managed Care Task Force (MCTF):
Dr. Gene Sherman was present to discuss the progress of Late Resolution 11-P, "Senior Plan Formularies". He stated that Pueblo disagrees with the actions of the MCTF. Dr. Sherman stated that based on the interaction of the MCTF and the Formulary Committee, that they do not believe it is in the best interest of CMS to pursue legislation on senior formularies. Dr. Sherman recommended to the Board that HMO pharmacy directors write a series of articles for *Colorado Medicine* regarding policies and procedures for dealing with senior formularies. The MCTF is also recommending that an educational program on all managed care formularies be conducted at the CMS Annual Meeting.

Next meeting: September 11, 1997, 2:00 p.m., Snowmass Conference Centerm Snowmass, Colorado

Here's Our Agenda

It's simple. It's straightforward. And it represents the future of medicine. The American Medical Association presented to the Republican and Democratic leadership this agenda for the upcoming 105th Congress. Your AMA membership strengthens our voice in support of physicians and their patients. . . and will enhance our efforts to turn these goals into reality.

- **Patient Protections** Above all, preserve the ability of physicians to act as advocates for their individual patients. Do not allow insurers to "gag" physicians or withhold medically necessary treatments from their patients.

- **Medicare Reform** Make the Medicare program solvent. Expand patient choice of plans. Allow future growth rates that cover patients needs. Retain special protection for the vulnerable and elderly.

- **Medical Education and Research** Continue to support medical education and research so we can find cures for killers such as AIDS and cancer.

- **Public Health Problems** Expand prevention and treatment programs to combat AIDS, drug abuse, smoking and violence. These problems cost billions of dollars and millions of lives.

- **Liability Reform** Enact meaningful liability reform to ensure fair compensation to patients with legitimate claims while eliminating excessive malpractice awards that lead to defensive medicine.

Join or renew your membership in the AMA today — call 800 AMA-3211

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Report to the Board



by Leigh Truitt, MD
Managed Care Consultant
to the Colorado Medical Society

During the time since the last Board of Directors' Meeting, I have participated in the following activities:

• **Data Committee and Joint Data Project:** This is moving forward but at a slow pace. The Project has support from the HMOs and the meetings have been well attended. Patricia Byrns, MD, who is the project leader, is now in Chicago with the American Medical Association. She has provided excellent direction but the Project does need additional local leadership as well to keep it moving.

• **Medical Records Legislation Subcommittee of the Colorado Bar Association:** The most recent meeting was cancelled and there has been no activity.

• **Colorado Cooperative for Clinical Guidelines** Several meetings of the Steering Committee and the Subcommittee have been held and the project is moving forward but slowly. A preliminary grant application has been submitted to the Robert Woods Johnson Foundation for funding. Eric Book, MD, has left Primera so there is a leadership void at present. The Implementation Subcommittee is working to validate a diabetes guideline that can be coordinated with the Joint Data Project mentioned above.

•**Workers' Compensation Committee** I have attended several meetings of the Workers' Compensation Committee because of the issue of selective contracting by CCIA. At the request of the Committee, I met with Richard Stieg, MD, the Medical Director of CCIA, and reviewed its contracting policies, utilization management programs, quality assurance programs and credentialing policies. CCIA is working to secure CMS input into the membership of its credentialing process.

• **Formulary Subcommittee of the Managed Care Task Force:** I have participated in one meeting as the formulary issue has been involved in one physician termination from a managed care plan.

• **CMS/Colorado HMO Association Joint Committee:** At the meeting on Wednesday, June 4, 1997, I made a report to the HMOs about the scope of physician concerns. I was asked at that time to communicate to the provider relations and quality assurance departments of the HMOs our willingness to be involved at an early stage with individual physician issues.

• **Health Affairs Council:** I attended a meeting of the Health Affairs Council during which the AMAP program was discussed as this has repercussions for physician credentialing and profiling.

• **Profiling Committee:** We are still awaiting a decision by the Executive Committee about a seminar on commercial profiling systems to be held in the fall. I have had an additional meeting with Value Health to discuss changes in their system.

I am currently representing several physicians who have grievances about their relationships with HMOs, a physician who was terminated from an HMO, a physician who has been unable to join the panel of several managed care plans in midtown Denver, and a physician who believes that a hospital has denied him fair access to patients. If you have individual concerns about managed care issues, please call me either directly at (303) 321-2598, extension 103, or through the Colorado Medical Society.

You're too busy practicing medicine to play politics

Fortunately you have COMPAC. The Campaign Reform Amendment and legislator turnover in both Houses in 1998 may dramatically affect the legislative advances that have been made for you and your patients.

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They're just $4.25 per deck including postage and handling. All proceeds go to the Colorado Medical Foundation, so this is one bridge hand that's a win-win-win situation. Order now!

You needn't be the "dummy" in this hand. Whether you play convention, tournament, Masters or social, you'll love these cards. Just mail the coupon below with your check. Supplies Are Limited! So Hurry!

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CROP ploughs ahead

by Suzi Shevell,
CMS Dept. of Health Care Policy

"Program design continues to evolve."

Exciting things are happening with the Colorado Rural Outreach Program (CROP). To begin, the Colorado Medical Society has contracted with a new firm to guide us through the next crucial phase of the capital campaign. We are excited to be working with Ron Mirenda and Susan Holt-Landrum of Mirenda & Associates.



Ron Mirenda and Susan Holt-Landrum.

Ron Mirenda, founding principal of Mirenda & Associates, brings over 26 years of fund-raising, public relations and communications experience to the project. During his career, Ron has managed or played significant roles in campaigns whose combined goals approached $500 million. Susan Holt-Landrum brings with her 10 years of non-profit fund raising and administrative experience. Her annual giving campaigns achieved 100 percent participation from all internal constituencies and exceeded their dollar goals by 10 percent annually.

Program design continues to evolve as staff participates in events related to rural health care. Staff recently attended the 6th Annual Rural Health Conference in Montrose, Colorado, which is put together by the Colorado Rural Health Center. The CROP was exhibited and we attended several of the break-out sessions. Our conversations with other conference attendees were, as always, enlightening and encouraging with respect to the ongoing development of the CROP.

In the spirit of learning how best to assist rural communities and physicians in their attempts to create long term relationships, CMS will also attend the Colorado Opportunities Fair in September. Staff will present CROP at the exhibitors forum, and then spend time meeting with both rural communities in need of physicians, and residents who will be looking for that perfect practice situation. This event should be an invaluable experience.

Additionally, staff is working with Clydette Stulp and Roger Corbman to develop a workbook and training sessions on recruitment and retention for rural communities. Objectives for the training sessions and workbook are to help rural communities:

1) Identify ways of "finding the match" between their practice opportunity and the physician's practice needs.
2) Identify keys to retaining a physician in their community.
3) Identify keys to successful physician contracting.

The first workshop is planned for October 17.

So, as the capital campaign continues, so does the program development and community outreach portions of this very important project.

CME and the evolving system of accreditation

by Lorraine Heth,
CMS Dept. of Health Care Policy

The Accreditation Council for Continuing Medical Education (the national accreditation body for CME) has approved working version of a set of accreditation standards for a new system of accreditation. These standards will undergo continuing evaluation, but they should be ready for implementation by 1998.

As a state given the authority by ACCME to accredit organizations on a statewide basis, the Colorado Medical Society can design a system that meets the CME needs and culture of our physician community. CMS will, however, be required to have processes and standards that are compatible with the ACCME system and be able to demonstrate that compatibility when we are reviewed.

The new system has adopted what was best from the former Essentials and Standards while attempting to streamline a process that has become cumbersome in its demand for excessive documentation. In the new system, there are three *Critical Essentials* and two *Standards*. Each Essential and Standard is accompanied by items that sponsors will need to accomplish in order to demonstrate compliance. The Colorado Medical Society will be studying a mechanism for you to maintain your accreditation through an internet logging of activities. If we determine it is feasible to set up such a system, it will be described in another issue of *Colorado Medicine*.

One year ago, the state medical societies formed a national communication network, organized by region, for the development of this new system. It was a thrilling experience to begin with paper memos and reports and end with all regions connected by internet e-mail. Colorado was successful in connecting with the majority of the Rocky Mountain States Region through electronic means as well.

The annual state medical society meeting with the ACCME in September will devote a great deal of time to discuss implementation of this new system.

Journal-Based CME

In surveys and interviews with rural physicians the Colorado Medical Society has learned that there is a need to have access to credible CME.

In light of the society's commitment to rural communities and the physicians who practice within them, Journal-Based CME may be a desirable adjunct.

The CMS Committee on Professional Education and Accreditation will sponsor Journal-Based CME activities to provide continuing medical education to physicians who would otherwise not have easy access. CMS is currently piloting this project with a small group of physicians. After the pilot is evaluated and appropriate management tools are in place, CMS will make Journal-Based CME activities available to medical communities throughout the rest of the state. This exciting new program is planned to be available by the end of the year. If you have questions or would like a copy of the guidelines and charges, please contact Lorraine Heth at (303) 930-0409.

"CMS...can design a system that meets the CME needs and culture of our physician community."

Long Range Planning:
Political Pain Management

by Barbara R. Reed, MD
Member, Board of Directors
Colorado Medical Society



CMS President Ray Painter called me some weeks ago and asked me to chair the newly-activated Long Range Planning Committee. As I told him, this is an intimidating task. Sometimes it is hard enough to just live in the present, uncertain world. What with the extent of the uncertainty, it is not easy to think about what may be happening five or ten years from now.

But if we do not plan, if we just embrace ourselves for the future, we will be putting ourselves at an extreme disadvantage. Although the CMS is quite successful now, the very actions we have used to become successful, and will continue to use unless we try to change — those very actions may have to be modified. In fact, some of them may very well be outdated. The world has changed around us, and it is change that we must expect.

But change is hard. In order to change, we must embrace the unknowable. The unknowable is feared: What will the future hold for me? I like the present, and the past even more. What if the future is worse? Our egos are on the line: What if we are wrong about what we predict? What if we take a step in the wrong direction? What if we, as an organization, disappear, despite all our efforts?

In order to change, it is likely that we will have to give up some of those comforts we have loved. We should identify these, and be prepared to sacrifice those which are destined to go.

What is the upside of all this?

The upside is that it will force CMS to look critically at where it is, and evaluate where we want it to be. We will be focused outside ourselves and our lives and our practices at what is good for the patients of Colorado, and how we might participate in providing health care to those patients—in what context, with what partners, under what administrative umbrella. Focusing on an ideal will help us crystallize our beliefs, and help us to position ourselves such that we can anticipate upcoming events in a productive way.

Long Range Planning Committee Background Information

The Long Rang Planning Committee has launched its discussions, with our first meeting on April 23, 1997.

The Long Range Planning Committee Mission Statement is the following:

1. To evaluate ongoing and perceived future needs of the Society with regards to the functions it performs.
2. To review and evaluate the activities of the Society in terms of its overall mission and goals; specifically to develop and recommend a vision, mission, of the Society to the Board of Directors.
3. To evaluate the current strategic planning activities of the Society.
4. To study and to recommend changes to the Mission Statement of CMS, if needed.
5. To serve in an advisory capacity to the President and the Board of Directors regarding the above issues.

We recognize that a society must form its plan not only by studying and evaluating the reasons for the success of our strategies of the past, but also by taking a considered look at the future.

Recognizing that this task is difficult, and that those who have a history of participation in the Society will be well-positioned to explain how the steps were taken, we are identifying them as our Experienced Group. Members of the Experienced Group must have been in practice for more than ten years and/or had extensive contact with the Society and its functions.

It is our hope that a second group will be formed. For want of a better name, it will be called Newcomers—or those who have been in practice for fewer that ten years and/or who have not had extensive contact with the Society and its functions. We will meet separately at first, and then together to form a consensus.

Long Rang Planning Committee Notes of 4-23-97

At our formative meeting we discussed the following:

1. Mission Statement:

The Mission Statement of the Colorado Medical Society now reads:

"Advocating excellence in the profession of medicine and the provision of medical care."

Our initial proposal is that the Mission Statement be changed to the following:

*"Advocating excellence in the profession of medicine and **in** the provision of **health** care **to the people of Colorado.**"*

Our final recommendations of the Mission Statement will be made to the Board of Directors in the late summer. Further changes from the Newcomer group or from the membership at large will be considered.

2. Mechanisms which CMS has previously used to try to identify goals and priorities.

We have been provided with a volume of materials which include:

a. Summaries of the past two CMS Leadership Conferences (1995 and 1996).
b. Reports of previous Long Range Planning Committees of CMS, which last convened almost 10 years ago.
c. Reports of current Long Range Planning Committees of the Arapahoe Medical Society, which meets currently.
d. The AMA Report of the Study of the Federation.

These documents and others, as we become aware of them, will be used to guide us in our thoughts about the future of CMS.

Request for Contributions

Some of us will choose to remain in the past, to live out our practice days without any modification. Members of this group are focused on their own future; they must not be condemned. We ask only that those who choose this path—who are narrowing consideration of the future to yourself and your family—avoid criticism of those who choose to focus on the future.

To those of us who choose to take the risk to look at the future, we ask that you share your vision and your suggestions. We have kept the Long Rang Planning Committee fairly small but diverse.

Ideas considered will not be limited to those of members on the Long Range Planning Committee. Please participate in the ongoing process, so that you may feel you are a part of the consensus.

Do you have a vision of the future of CMS? Is your passion Strategic Planning? What will the practice of medicine look like in five or ten years? Where are our patients likely to be seen? Who will be providing health care, and in what scenarios? How does the Society need to change to be an integral part of this perceived future? What will be the needs of physicians in the future? Will there be different needs for different groups of physicians?

We welcome your thoughts.

Please send comments to Barbara Reed, Chair of the Long Range Planning Committee, c/o Debbie Jones, at CMS, 1-800-654-5653 x 2422, (303) 930-0422, **fax** (303)771-8657. E-mail: *Debbie_Jones@cms.org.*

How are the children?



by Stella Shanks, CMSA President

I heard a story last month while attending a vigil organized by the Colorado Coalition for Children, that I though so well answered an oft asked question. Is the medical alliance still needed?

The story goes... in Kenya, Africa, there is a nomadic tribe called the Masai. These respected warriors have a traditional greeting as they meet each other. "And how are the children?" they ask. The answer is, "the children are well," and that indicates that they, the tribe, are in good shape and their society is prospering.

If that question were asked of our society today, could we say that the children in our society are well? They are not. Our children are neglected, poor, illiterate, homeless, abused, without care, both medical and otherwise. They are missing, molested and even murdered. Their mothers are poor, uneducated, unable to care for them. Their fathers are often missing.

When I look at our alliances, I think of the parable of the talents, "To whom much is given, much is expected." We have had the advantages of education, opportunities for advancement, adequate housing and food, and access to care of all sorts.

We, as an organization, can do a lot to make the children well. We have the opportunities to share our talents, our education, our resources to help these mothers and children. Our identity should be that of a giving organization. Not one where we struggle with what the benefits should be to us because we belong.

Is the alliance needed in today's society? Yes, even more so than when we organized 75 years ago.

As we end one year in the organization and prepare for a new one, let each of us give a little of our talents, so that we can proudly say, "Our children are well".

Traditional vs. virtual medicine:
A fight to the finish?

by Chet P. Seward,
CMS Communications

"The 'gods in white coats' image of physicians has been debunked."

The days of the "family doctor" who made house calls and oversaw the health care of families from generation to generation are gone. Many physicians fondly recall those "good old days" when the doctor's word was above challenge and once a physician was chosen it was for life. Today, a host of different factors prevent most physicians from playing the "family doctor" role. However, many physicians still practice in "traditional" manners with little or no intervention from outside sources through close doctor-patient relationships and joint doctor-patient decision making. Other physicians practice an almost futuristic or virtual medicine utilizing the newest and best technological, administrative and practice management advances available. Sometimes the distinction between the two is blurred, while at other times some categorize the differences as the battle between good and evil. Has the rush to automate medicine adversely affected the physician-patient relationship and quality care? Is medicine in too big of a hurry to embrace new interventions between the physician and patient?

White coats and collage of factors

The dynamics of the physician-patient relationship have changed. With the advent of managed care, perhaps even society's perception of medicine has changed. Patients are taking a more active role in their care. The "gods in white coats" image of physicians has been debunked. This shift is due in part because of physician behavior, but it is also a result of the continuing evolution of both the practice and the business of medicine. There has been an enormous surge in the demand for more information and better communication. Computers and other technologies have led this charge. The government, Wallstreet and others have focused on accountability and fiscal responsibility. Throughout it all the cries for lower cost, quality care have continued.

It is within this collage of factors that the lonely provider and the patient stand. Their relationship is always the same, but the way it is nurtured can be vastly different. Some would argue that the difference between traditional and virtual medicine is nothing more than semantics. The end goal has been and always will be quality care.

Virtual medicine today has allowed third parties, like managed care companies or electronic, clinical protocols, to intervene and change the "traditional" reality which is based upon joint doctor-patient decision making. In certain ways physicians and patients are now once removed from each other. Many "traditionalists" have retired, refusing to change. Others continue to struggle to find a happy medium.

Classifying it as a battle between good and evil may be too extreme. The reality is that "virtual" medicine is here to stay. The reality is that the protocols, electronic records and third party payers will continue to capitalize on physicians' time and intervene on the scant eight minute average patient visit. The reality is, as many physicians have come to understand, medicine should have expected nothing less.

Recent studies have shown that patients are concerned about restrictions on choice of physicians. They are also worried about receiving the quality of care that they deserve. Doctors are worried too, and that concern is the basis for optimism.

The science of medicine is not a zero-sum game. It is an ever evolving art. Traditional or virtual, the focus of medicine will always be on the patient. Today's virtual medicine is a manifestation of that care.

There have been setbacks, and in ways physicians have lost control of the system. Perhaps this is in recompense for more prosperous times, or maybe it is because doctors have taken longer than expected to matriculate into the new system. The point is that the focus is still centered on providing the patient with the best possible care with the tools and practices that are available. This can amount to traditional practices, or futuristic/virtual procedures. The interventions that help define today's virtual medicine are just factors to be considered.

House calls

Has virtual medicine adversely affected the physician-patient relationship and quality of care? It depends who you talk to. Both sides have legitimate arguments. It may be too early to determine if quality has changed or suffered. Maybe the answer can be found in patients. Recent legislative backlashes against managed care organizations and legal reforms prove their trust in the physician-patient relationship. And while new technologies are clumsy at first, patients generally welcome automation if it provides a few more minutes with their doctor.

Should the battle between traditional and virtual medicine be depicted in such epic terms as knights slaying dragons? Maybe the dragon of change is actually just another horse for physician knights to ride on their way to their next patient visit.

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THE NUMBER 1 REASON YOUR PATIENTS WILL HAVE A MAMMOGRAM THIS YEAR.

No matter what your specialty, the American Cancer Society needs you to recommend an annual mammogram for every woman over 50. An annual mammogram is critical for early detection and intervention, yet too many women are not hearing this message. Take the first step. Call 1-800-ACS-2345 for information that can help you make an impact.

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EVERY YEAR AFTER 50

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AMERICAN CANCER SOCIETY

COLORADO MEDICAL SOCIETY
AND COLORADO MEDICAL SOCIETY ALLIANCE
1997 Annual Meeting Schedule

Snowmass Conference Center/Silvertree Hotel, Snowmass Village
September 12-14, 1997

THURSDAY, SEPT. 11

8:00 am-	CMS Office open
7:30 am-	18-hole Golf Tournament
1:00 pm- 2:00 pm	Finance Committee
2:00 pm- 5:00 pm	Board of Directors
4:30 pm- 8:00 pm	Registration open
6:00 pm- 7:30 pm	Welcome Reception
7:30 pm-	Dinner on your own

NOTE: Dress for Annual Meeting

Thursday evening reception ....
Friday: ..... casual
Saturday morning: ..... casual
Saturday inaugural dinner/dance: coat-tie/dressy business attire or cocktail dress
Sunday: ..... casual

FRIDAY, SEPT. 12

7:00 am--	CMS Office opens
7:00 am-- 5:00 pm	Registration
7:00 am-- 7:45 am	Reference Committee Breakfast
7:00 am-- 7:45 am	New Delegate Orientation Brkfst
7:00 am-- 7:45 am	AMA Delegation Forum Brkfst
8:00 am- 12:00 N	Exhibits open
7:45 am-- 8:00 am	Credentials Committee
8:00 am-- 8:30 am	Opening Session House of Delegates
8:30 am-- 9:30 am	Alliance Board Breakfast
8:30 am- 12:00 N	General Membership Meeting
9:30 am-- 9:45 am	Coffee break
9:45 am- 11:45 am	Alliance General Meeting
12:15 pm- 1:45 pm	COMPAC/CMSA Luncheon
2:00 pm-- 3:00 pm	Alliance Workshop
2:15 pm-- 3:15 pm	Copic Risk Management
2:15 pm-- 3:15 pm	Copic Risk Management
2:30 pm-- 4:30 pm	Reference Committee
3:00 pm-- 4:30 pm	Alliance County Breakout Sessions
3:30 pm-- 5:30 pm	Reference Committee
3:45 pm-- 4:45 pm	Copic Risk Management
3:45 pm-- 4:45 pm	Copic Risk Management
4:00 pm-- 7:00 pm	Exhibits open
5:30 pm-- 7:00 pm	Exhibitor Reception
6:30 pm-- 8:00 pm	Women in Medicine Dinner and Business Meeting
6:30 pm-- 7:30 pm	Colorado Society of Internal Medicine Annual Meeting
7:00 pm-- 9:00 pm	Gone But Not Forgotten Dinner (by invitation only)

SATURDAY, SEPT. 13

7:00 am-	CMS Office opens
7:00 am- 11:00 am	Registration
7:30 am- 8:20 am	Prayer Breakfast
7:30 am- 8:20 am	Educational Program Continental Breakfast
7:00 am- 11:00 am	Exhibits open
8:30 am- 12:00 N	Educational Program
8:00 am- 12:00 N	Alliance Meeting
12:00 N-	Recreation Time - golf, tennis, horseback riding, biking, fishing, walking, etc.
1:00 pm- 3:00 pm	Drug Formulary Forum
1:00 pm- 4:00 pm	Copic Seminar
5:30 pm- 6:15 pm	Cocktails - cash bar
6:15 pm- 7:00 pm	Inaugural
7:00 pm- 10:30 pm	Presidents' Dinner/Dance
9:00 prn- 10:30 pm	Copic Dessert Reception

SUNDAY, SEPT. 14

6:30 am-	Reference Committee Reports available
7:00 am-	CMS Office opens
7:00 am- 10:00 am	Registration
7:00 am- 8:30 am	Component Caucuses
	Arapahoe
	Aurora-Adams
	Boulder
	Clear Creek Valley
	Denver
	El Paso
	Larimer/Weld
	Pueblo/Western Slope
8:00 am- 8:30 am	Credentials Committee
8:30 am- 12:00 N	Closing Session HOD
9:00 am- 10:00 am	CMSA Gavel Club Breakfast
12:00 N (or immediately following HOD)	Reorganizational Board Meeting



Joseph Bujak, MD, FACP, to keynote Annual Meeting



Renowned health care futurist, Joseph Bujak, MD, FACP, will be the keynote speaker at the 1997 Annual Meeting of the Colorado Medical Society. Dr. Bujak will focus on the major dynamics transforming the health care industry and how they are impacting physicians. He will critically assess the way physicians currently approach patient care, and examine the factors that cause an absence of health in populations. What's at stake for you as the tactical forces of health care continue to change, what is your business, and what is it that you value both professionally and personally? Difficult questions and challenging answers will be explored as Dr. Bujak engages you in determining if there is a better way.

Dr. Bujak currently serves as Vice President, Medical Affairs for Kootenai Medical Center, Coeur d'Alene, Idaho, and VHA's Mountain States region. A dynamic speaker, he understands the stabilizing role of positive vision and strongly held values. He works toward developing leadership and followership, especially in the physician community.

CMS Annual Meeting Golf Tournament

at the Snowmass Club Golf Course
Thursday, September 11, 1997
Entry Form

Name _____

Address _____

Please give us the following information for tee times and emergencies

Office Phone _____ Home Phone _____ FAX# _____
(necessary for reservations)

While in Snowmass I will be staying at _____

I will be attending the meeting in the capacity of (check one)

❑ Physician ❑ Exhibitor ❑ Spouse ❑ Other

I will: ❑ Sponsor a golf course hole @$100 ❑ Sponsor a putting green contest hole @$50

Name of sponsor (as you wish it to appear on sign) _____
(Professionally made signs will be displayed for sponsors.)

My golf handicap is _____ or my average score is _____

Please reserve a set of ❑ **Left handed** ❑ **Right handed** clubs for me. I will pay the $30 rental fee on site.

If you would like to play please return this entry form as soon as possible because space is limited. ***CMS has reserved tee times, starting at 7:30 a.m. for only eight foursomes.*** Play will be scramble format. Foursomes will be arranged according to various levels of ability by the golf professional. If you have a preference of who you are teamed with, please specify below. Prizes will be awarded for a variety of categories to include closest to the pin and longest drive. To ensure tournament entry, registration form and advance payment of $95 must be received **no later than** August 21, 1997. Cancellations received after August 21, 1997 are refundable subject to ability of Snowmass Golf Club to "resell" vacated tee times.

You will be notified regarding tee times. A shotgun start will not be possible, therefore, please be prompt with your tee times. To reserve other personal tee times, please call the Pro Shop at (970) 923-5600.

I prefer to be teamed with _____

* Mail Entry Form and check to Barbara Campbell, 2251 Ash Street, Denver, CO 80207. Make checks payable to Barbara Campell. For additional information please call Barbara Campbell at (303) 388-5307

Colorado Medical Society
Annual Meeting
September 12-14, 1997

Snowmass Resort Association
P.O. Box 5566
Snowmass Village, CO 81615
Phone (970) 923-2010
1-800-598-2004 FAX (970) 923-4260

If reservations have already been made directly with the hotel, please do not send this card. To make reservations by mail, please complete the following and mail to the address above. To guarantee these special rates, ***reservations must be received by August 28, 1997.***

Name _____

Name(s) of additional person(s) sharing room: (# of adults _____# of children _____)

_____

Address _____

City _____ State_____ Zip _____ Phone ( ) _____

Arrival date _____ Departure date _____

Please reserve the following: (Special rates apply from September 9-17.)

❑ **Silvertree Hotel Lodge Room** ($113 per night for 2 persons, each additional $25)

❑ **Wildwood Lodge Room** ($100 per night for 2 persons, each additional $25)

Payment type–Personal check or major credit card may be used to secure deposit. One night's lodging required.

Silvertree Dbl.	**$113 + tax**
Wildwood Dbl.	**$100 + tax**
Check-in Time:	**4:00 pm**
Check-out Time:	**11:00 am**

Type of card _____

Card # _____ Exp. Date _____

Name of Cardholder _____

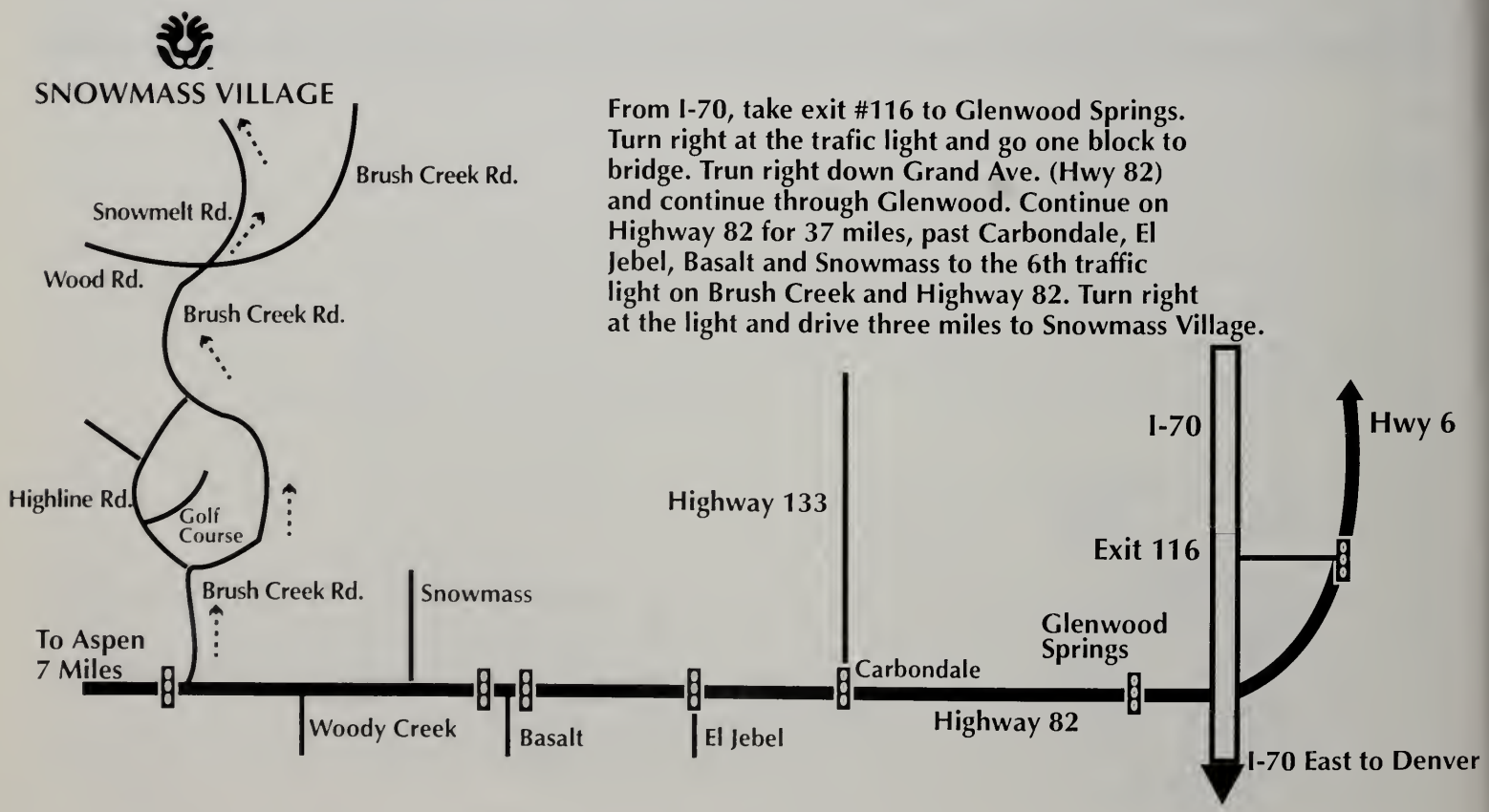
"I authorize Snowmass Central Reservations to charge my credit card for the deposit and prepayment for accommodations listed above."

Signature _____ Date _____

Children 12 and under stay for free in parent's room with existing bedding. Current sales tax is 11.5% (subject to change). CANCELLATION POLICY: If cancellation occurs 14 days or more prior to arriaval, there is a 10% handling fee. If cancellation occurs less than 14 days prior to arrival, deposit is forfeited unless room is re-rented. If re-rented, full refund will be made, less 10% handling fee.

Please let us know how we may accommodate any disability or special request.

GETTING TO SNOWMASS VILLAGE



From I-70, take exit #116 to Glenwood Springs. Turn right at the trafic light and go one block to bridge. Trun right down Grand Ave. (Hwy 82) and continue through Glenwood. Continue on Highway 82 for 37 miles, past Carbondale, El Jebel, Basalt and Snowmass to the 6th traffic light on Brush Creek and Highway 82. Turn right at the light and drive three miles to Snowmass Village.

Annual Meeting Registration

1997 Annual Meeting of the Colorado Medical Society and CMS Alliance
September 12-14, 1997, Snowmass Conference Center, Snowmass Village, Colorado

Name (please print) _____

Component Society _____ Names of Spouse/Guest(s) (if attending) _____

If you are not a member of CMS, please provide the following:

Company/Organization _____ Title _____

Reservations for Events and Meetings

Reservation deadline is August 29, 1997. (Note: To attend the President's Dinner Dance on Saturday, you **must obtain** your tickets before noon, Friday, Sept. 12.) Reservations accepted on a first-come, first-served basis (may be limited for some programs). For purposes of registration, staff of county medical societies are considered members. You must indicate the number of attendees for each function so that we may be cost efficient with food/beverage orders.

As a member, ***you and one guest are entitled to attend the complimentary events at no charge.*** Please indicate the number of additional guests at the bottom of this form and enclose your check.

Complimentary events open to all members: Please indicate below which functions you will attend.

THURSDAY, SEPTEMBER 11

6:00 pm	Welcome Reception	member ❑	guest ❑

FRIDAY, SEPTEMBER 12

7:00 am	New Delegate Orientation Breakfast	member ❑	
7:00 am	AMA Delegation Forum Breakfast	member ❑	
7:00 am	Reference Committee Member Breakfast	member ❑	
12:15 pm	COMPAC/CMSA Luncheon	member ❑	guest ❑
5:30 pm	Exhibitor Reception	member ❑	guest ❑

SATURDAY, SEPTEMBER 13

7:00 am	Educational Program Continental Breakfast	member ❑	guest ❑
8:00 am	Educational Program	member ❑	guest ❑
7:00 pm	President's Dinner Dance:		
	(Please select menu from below)		
	Beef and Chicken Dinner	member ❑	guest ❑
	Vegetarian Dinner	member ❑	guest ❑
	Vegan Dinner	member ❑	guest ❑
9:00 pm	Copic Dessert Reception	member ❑	guest ❑

Additional Reservations (other than member + 1 guest):

Educational Program Breakfast	# _____	@$15 each=	_____
President's Dinner Dance (**Reservations necessary**, please select menu below)			
Beef and Chicken Dinner	# _____	@$50 each=	_____
Vegetarian Dinner	# _____	@$50 each=	_____
Vegan Dinner	# _____	@$50 each=	_____

..... Total for Additional Reservations $ _____

Non-Complimentary Events:

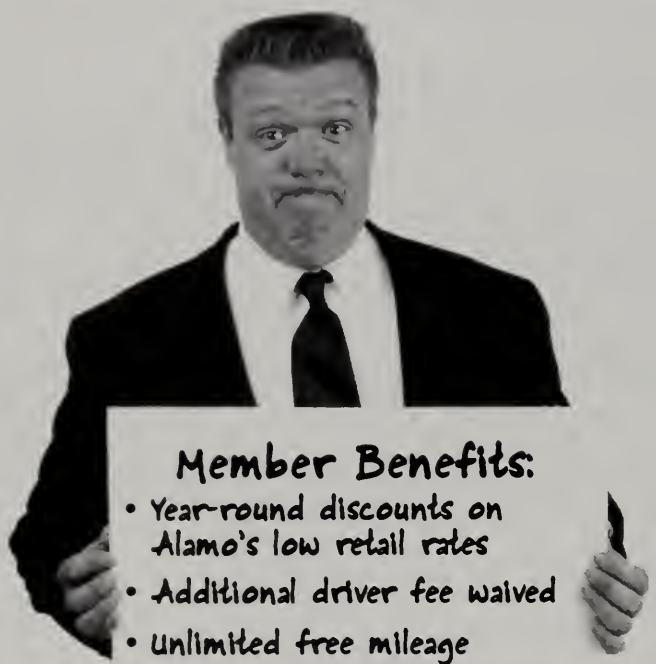
		Cost	Number
FRIDAY, SEPTEMBER 12			
12:15 pm	COMPAC/CMSA Luncheon	$20 each	_____
	..... Total for Non-Complimentary Reservations		$ _____

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CopicComment

by Jerome M. Buckley, MD
Chairman & CEO
Copic Insurance Company



"The Case for Long-Term Care Insurance, Part 1"

The "baby boomers" are getting old... and some of us "pre-baby boomers" are getting even older. These simple facts dominate every part of the current debate over healthcare and healthcare financing. And as the boomers age, they will leave their unique mark on elder care and geriatrics just as they did on every other American institution through which they have passed.

Consider that today, our over-65 population numbers 33 million; by 2020 it will jump to almost 54 million. Meanwhile, as more and more of us age, that old age is lasting longer than ever. We physicians can be justifiably proud of the medical and scientific achievements that have made this possible, but the combination of a demographic bulge **plus** increasing life expectancy **plus** medical inflation due to caring for the elderly will strain America's healthcare financing models past the breaking point.

Decades ago, the United States established a "pay as you go" system for Medicare, using life expectancy assumptions that are now known to have been inappropriate and are therefore very costly for the post-boomer generation of taxpayers being asked to provide healthcare for aging boomers. When added to the Social Security burden and our ever-increasing government debt financing, the combined price tag could force taxes to levels previously unknown in America.

To get a sense of the numbers involved, an average nursing home stay in 1994 cost $100,000.[1] According to the New England Journal of Medicine[2], more than 43% of seniors will spend time in a nursing home. Fully half of us (that includes physicians, too) who reach the age of 65 will need some type of long term care, either in the home or in a community or institutional setting. The bill for this care gets to be pretty daunting when half of the 54 million graying boomers need care to the tune of $100,000 each. A trillion here, a trillion there...

Given the independent nature of the boomer generation, it is safe to assume that whatever we plan today will end up being radically modified as the children of the '60s roll their way through old age. But no matter how their care is eventually supplied, the truth is that it will cost more than future taxpayers (our children) can afford.

Congress has telegraphed this message ("plan to take care of it yourselves") to us in the recent Kennedy-Kassebaum legislation by creating favorable tax status for qualified long term care insurance plans. The essence of the legislation is that people who are in a position to take care of themselves will be obliged to do so. Medicare currently pays less than 2% of all long term care costs[3], and the legal loopholes through which the middle classes deliberately impoverish themselves in order to become eligible for Medicare are being closed. The writing on the wall says that government care for the elderly will be means-tested and we had better plan on providing for ourselves.

Behind the politics and the scare-mongering, there is a real opportunity for improvement in the long term care we provide for our patients and for ourselves. The good news is that so long as the tax code encourages prudent self-reliance on the part of the public, the provider-patient relationship will likely be protected from interference by third-party payers (both governmental and commercial).

Physicians have to face the challenge of this medical, financial, and demographic "triple-play" whether we want to or not. As a profession, we have seen all too clearly how commercial interests hamper our ability to care for patients. A system of individually-owned long term care insurance plans will help ensure that when our patients are at their most frail and vulnerable (and, for that matter, when we are), we will be able to serve their needs and provide for our own long term care needs as well.

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2 NEJM, 2/28/91
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Medical Acupuncture: A model of integrated healthcare from *Alternative* to *Mainstream* medicine

by ***Bryan L. Frank, M.D.***
Diplomate - American Academy of Pain Management
Colorado Springs, Colorado

"... a cornerstone of over 300 drug rehabilitation units nationwide."

Abstract: The integration of acupuncture into the mainstream of medicine is rapidly occurring in Colorado, as well as in the rest of the U.S. Significant decisions by the U.S Congress, the FDA, and various state and federal agencies will result in rapid assimilation of acupuncture into contemporary biomedical practices. Medical acupuncture, or acupuncture practiced by licensed physicians, offers a truly unique integration of diagnostic and treatment options from both modern biomedical practice as well as classic eastern and westem acupuncture traditions. It behooves the physician to become aware of the current trends in medical acupuncture in order to make informed referral decisions for their patients, or to become trained and thereby assimilate this very potent tool into their "black bag" of medical interventions.

Key words: Acupuncture, medical acupuncture, integrated medicine.

Introduction: Physicians are rapidly integrating acupuncture into their contemporary medical practices across Colorado and the U.S. Colorado currently has over 30 physicians who have completed training consistent with standards set for the practice of acupuncture by western trained physicians by both the American Academy of Medical Acupuncture and by the World Health Organization's affiliate, the World Federation of Acupuncture / Moxibustion Societies. Because of increasing basic and clinical research showing physiologic responses and dissatisfaction by the public of contemporary medicine's passion for expensive drugs and procedures, acupuncture is increasingly entering into a position of mainstream medicine, as opposed to being considered an alternative or complementary modality.

Historical Highlights: Most physicians will be surprised to know that U.S. physicians have actually been involved in the practice of acupuncture for approximately 200 years. Dr. Franklin Bache, prominent Philadelphia physician and a great-grandson of Benjamin Franklin, wrote the first U.S. medical acupuncture article entitled *Memoirs on Acupuncture* in 1825. Civil war physicians are known to have utilized acupuncture in the mid-1800s, and even Sir William Osler noted in his classic medical text the advantages of acupuncture for the treatment of lumbago and sciatica. These recommendations continued in his text reprints for nearly 50 years.

The emergence of allopathic medicine as the predominant practice style in the U.S. following the Flexner report in 1910 left a gap of nearly 50 years of U. S. physician involvement in various alternative therapies, at least in the open practice environment. President Richard Nixon's trip to China opened the "bamboo curtain" for much of the western world. When New York Times correspondent James Reston had an emergency appendectomy, his postoperative ileus and pain were treated with acupuncture with remarkable success. Since that time, the enthusiasm and guarded skepticism of various lay and professional groups has continued.

The January 28, 1993 *New England Journal of Medicine* article by Dr. David Eisenberg of Boston's Beth Israel Hospital and Harvard Medical School, noted that 34 percent of a random survey group sought relief for medical problems through such alternative therapies as acupuncture, chiropractic, homeopathy, herbal therapy, and more. Further, most patients had not informed their primary physician about the alternative therapies. In 1990, Americans spent an estimated $13.7 billion on alternative treatments, of which $20.3 billion was non-reimbursed, out-of-pocket expense.

The National Institutes of Health established the Office of Alternative Medicine by authorization of the U.S. Congress, whose mission is to facilitate the evaluation of various

(Continued on following page)

alternative therapies to determine their effectiveness and appropriate integration into the medical mainstream. Moreover, in 1996, the FDC reversed a twenty year decision on acupuncture needles with a change in status from "experimental" to a "Class II medical device". While the FDA never said that acupuncture per se was experimental, this labeling of the needles and other devices, as well as negative popular press articles and cartoons, served to dissuade patients, physicians, and third party carriers from considering acupuncture a serious part of twentieth century medicine. Currently, over 30 U.S. medical schools offer some level of training or orientation to acupuncture and other alternative therapies. Most physicians with interest in these alternative therapies express dissatisfaction with the contemporary practice of using expensive drugs and procedures, while many of their patients continue to suffer from common afflictions which modern medical marvels will not relieve. Clearly, one of the significant driving forces which has pushed acupuncture into a more mainstream model is the public demand for choices and availability of various therapies for common problems and pain conditions unresolved by contemporary drugs and invasive procedures.

East Meets West: With a rich history of over 2500 years, acupuncture is said to have treated more persons on earth than all other medical systems combined. Classic acupuncture physiology considers that pain and disease are the result of either an excess or a deficiency of Qi, loosely translated as energy. Classic acupuncture therapy, then, is designed to restore the balance of the body as a whole organism, with restoration of the balance of Qi. Because a patient is clinically different at each visit, it is critical to reevaluate the patient prior to treatment on each visit. The clinical response, or lack thereof, will guide the acupuncturist in selecting one of several treatment approaches for a pain or general medical complaint. "Qi" has been a difficult concept for many western physicians to accept, however, current understanding of this "energy" is consistent with the body's bioelectric fields. Bioelectricity is readily understood in myocardial activity, brain activity, and neuromuscular function. We routinely measure these bioelectric functions in the form of electrocardiograms, electroencephalograms and electromyelograms or nerve condition studies. Bioelectric therapies considered "mainstream" include cardiac pacemakers, bone growth stimulators, and TENS units. Dorsal column stimulators are used to give electrical input for end-stage pain problems. Even the use of biofeedback has gained widespread acceptance over the last twenty years in the treatment of chronic pain problems.

Western Medical Research: Over the last twenty five years, the greatest amount of western biophysiologic research on acupuncture and the peripheral and central nervous systems has come from Dr. Bruce Pomeranz, professor in neurosurgery at the University of Toronto, Canada. His studies have shown an impact of electro-acupuncture on the presynaptic and post-synaptic inhibition of pain signals by acupuncture stimulation. Neurohumoral compounds including endorphins, enkephalins, GABA, and also cortisol have been shown to be released by the effects of acupuncture stimulation.[1]

Western medical publications have shown the benefits of acupuncture in a wide variety of pain and medical problems. The World Health Organization recognizes the effectiveness of acupuncture for the treatment of various pain problems, as well as pulmonary, cardiovascular, digestive, gynecologic, neurologic, and psychiatric medical problems.[2] Acupuncture's effectiveness has been documented in cases of cardiovascular critical care such as cardioversion of supraventricular dysrrhythmia,[3,4] for treatment of renal colic,[5] and to arrest status epilepticus.[6] Bronchial asthma may respond to acupuncture,[7,8] as well as primary dysmenorrhea.[9] Clearly more medical research is needed and eagerly desired by those clinicians who have seen acupuncture add a whole new dimension to their patient care options. Recent research includes that of Margaret A. Naeser, Ph.D., a neurophysiologist from Boston University School of Medicine. Dr. Naeser has shown a significant recovery in paresis in post-stroke patients who receive acupuncture if CT scans showed lesions of less than 50% of the motor pathways, specifically the periventricular white matter area (PVWM). If, however, more than 50% of the PVWM was damaged, or if sham acupuncture was used (needle placement in non-acupuncture points), then acupuncture did not show significant benefit to the patients.[10] This type of research can give clinicians more clear guidelines to the appropriateness of acupuncture in various clinical settings.

In clinical practice, many physician acupuncturists not only see patients benefit from acupuncture treatment for pain problems of various sorts, but also may see lower steroid requirements in steroid-dependent asthmatics, improved responses to manual therapy, as well as decreased nausea, vomiting, bowel stasis, and urinary bladder distension in peri-operative settings. All of these clinical responses may lead to decreased patient morbidity, decreased cost of medicine, and improved patient care for many. Acupuncture has further been shown to be conclusively important to improve outcomes for addiction rehabilitation and is a cornerstone of over 300 drug rehabilitation units nationwide.

While acupuncture has a broad range of clinical indications for integration into a conventional biomedical practice, its overall complication rate is minimal. Occasionally, symptoms may flair for a few days, and this is generally followed by clinical improvement of the pain or medical condition. Hematoma, pneumothorax, and

(Continued next page)

viscus perforation are real possibilities, although these should certainly be rare in the hands of a qualified physician. Infection is extremely rare, as well, as the acupuncture needles are thin and solid, and minimally traumatize tissue as compared to a typical hypodermic needle commonly used in medicine. Clearly, physicians should use either disposable needles or needles sterilized in an autoclave, as they would with any other medical/surgical device in their medical practices.

Contemporary Colorado: Over thirty licensed physicians in Colorado have been trained to integrate acupuncture into their contemporary biomedical practices. Medical specialties represented include Family Practice, Internal Medicine, Anesthesiology, Physical Medicine & Rehabilitation, Neurology, and others. Most physicians have trained through the UCLA School of Medicine's Office of Continuing Education program, Medical Acupuncture for Physicians. This program offers training consistent with standards internationally recognized by the World Health Organization's affiliate, the World Federation of Acupuncture/Moxibustion Societies. The American Academy of Medical Acupuncture is a founding member of WFAS, and it represents over 1000 U.S. physicians who have met these internationally recognized levels of training. The AAMA leads in training, certification, and continuing education of physician acupuncturists. Its standards often serve as a model for hospital credentials, state practice requirements, insurance company standards, and liability insurance education requirements. The AAMA also offers a proficiency examination for physician acupuncturists and is in the development of a board examination, as well. Further, the AAMA's sister organization, the Medical Acupuncture Research Foundation, is developing significant research and educational opportunities for physician acupuncturists.

Conclusions: Medical acupuncture is being practiced by an ever enlarging number of Colorado physicians. The potential impact upon the physicians' practices and the care of patients is significant. Educational opportunities are increasing to allow physicians to become more aware of the rightful place of integrating acupuncture into a conventional practice and to thereby make appropriate referrals for their patients.

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Further Resources:

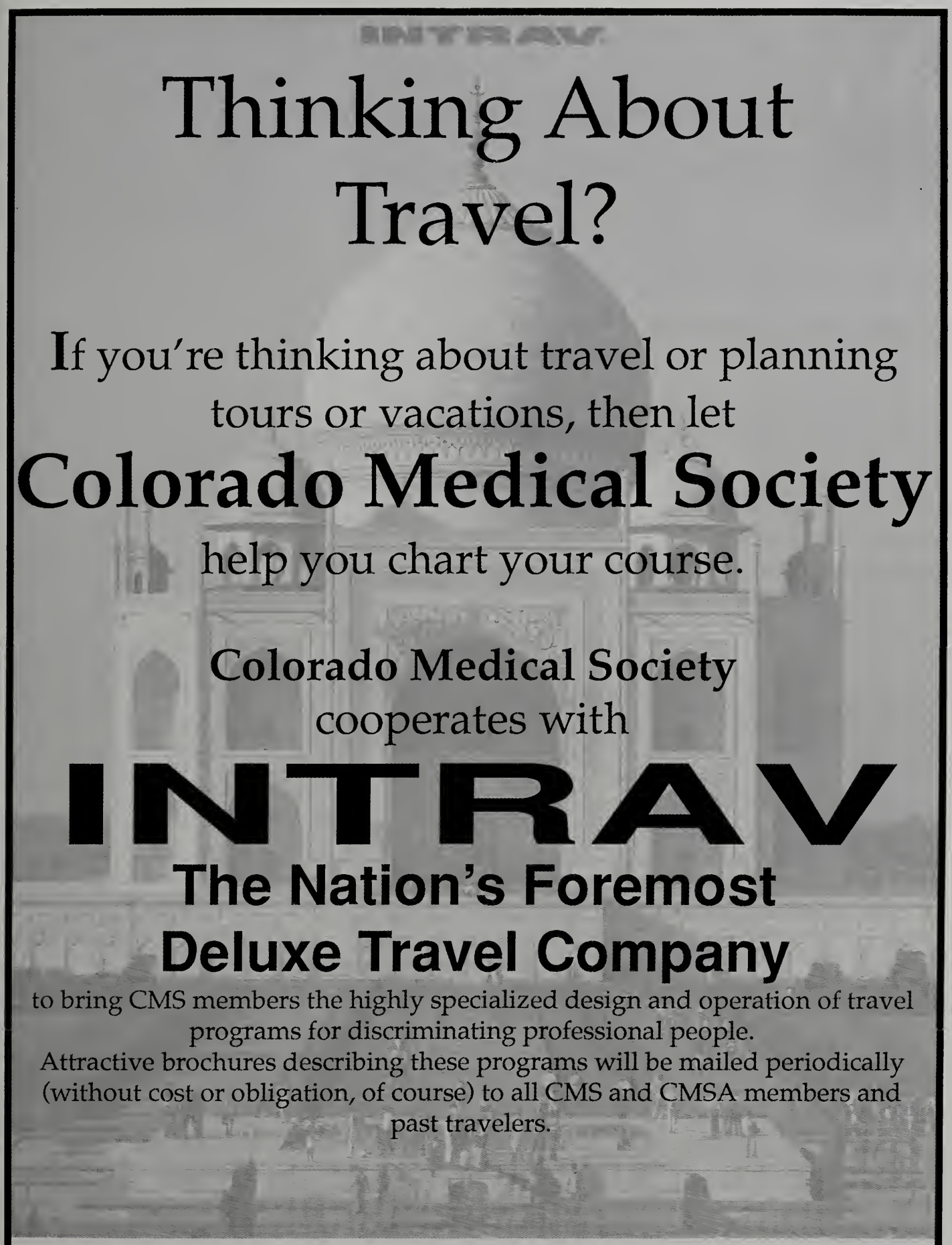
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Addendum: Physicians interested in integrating acupuncture into their biomedical practices have a greater opportunity than ever before in the U.S. medical system. The primary training program available in the U.S. is through the UCLA School of Medicine's Office of Continuing Medical Education Course, "Medical Acupuncture for Physicians".

This course offers an intensive didactic and clinical training program which is consistent with the internationally recognized standards for western-trained physicians by the World Health Organization. Through this course, physicians learn classic and contemporary theories of acupuncture, as well as "hands on" training with experienced practitioners.

Further, the physician interested in the integration of medical acupuncture into their contemporary biomedical practice may be interested in contacting the American Academy of Medical Acupuncture, the professional organization which represents over 1000 physicians who are trained at the national and international standards. The AAMA offers the standard for training, certification, and continuing education for physicians who integrate acupuncture into their western trained practices. The AAMA standards are often used for establishing hospital credentials, insurance reimbursement, and state practice qualifications.

For information regarding the AAMA, please call 213-937-5514. To inquire about the UCLA Medical Acupuncture for Physicians Course, please call 510-841-7600.



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Medicare fraud and abuse -
Clarifications in the carrier's role

by Marilyn Rissmiller,
CMS Dept. of Health Care Financing

Part Three of a Series

"...I would make such a referral only when the provider continues, after an educational effort by the carrier, to engage in fraudulent activity."

Grant Steffen, M.D., the Medicare Medical Director for the state of Colorado, clarifies the carrier's role in fraud and abuse.

He advises that, "Charges of fraud and their implementation **are not brought by the carrier**. I cannot charge anyone with fraud. This task is handled by the Inspector General's office or the FBI. The carrier **can** refer a provider to these agencies for their consideration.

...I would make such a referral **only** when the provider continues, after an educational effort by the carrier, to engage in fraudulent activity. **I would not make a referral just because of an honest mistake or confusion over the interpretation of Medicare rules**."

In response to a question raised at the May 15, 1997 meeting of the Colorado Carrier Advisory Committee, regarding what actions are taken when upcoding is found, Dr. Steffen explained there are three ways it may be handled. "First, education may be done, with a recheck of records in six months. Second, education and recoupment of the difference between what was billed and the service provided per documentation for the charts reviewed. Third, if there appears to be a serious problem a comprehensive medical review may be done, resulting in education and a projected overpayment for the entire period of review with recoupment. ...Of course, at any time, if the situation warrants, there may be a fraud referral."

In the previous articles in this series information has been provided on the Medicare Focused Medical Review (April 1997) and on the definitions of fraud and abuse used by the Medicare Carrier (May 1997). This final segment will address the Health Insurance Portability & Accountability Act (HIPAA) and how it has expanded the fraud and abuse statutes and sanctions. The fraud and abuse provisions of the law took effect January 1, 1997.

1. The new law increases the sanctions that may be imposed for violations of the fraud and abuse statute. Some of these include:
   - Mandatory exclusion for felony convictions in connection with the delivery of a health care item or service or involving controlled substances.
   - A minimum, three-year exclusion for convictions of misdemeanor criminal health care fraud offenses, criminal offenses relating to fraud in non-health care federal or state programs, convictions relating to obstruction of an investigation, and convictions of misdemeanor offenses relating to controlled substances.
   - A minimum one-year exclusion for people who provide items or services in excess of the needs of a patient.
   - Increases in the maximum civil monetary penalty from $2,000 to $10,000 per service, and increases in the maximum assessment from twice the amount claimed to three times the amount claimed.
   - Increases in the civil monetary penalties for falsifying home health claims.

(Continued following page)

2. The Medicare and Medicaid civil money penalties were expanded to cover all federal health care programs. The law also expanded the circumstances when penalties may be applied, for example:
   - Practitioners who show a pattern of presenting claims for items or devices based on a code that the physician knows (or should know) will result in greater payment than the physician knows (or should know) is applicable for the items or services actually provided (**upcoding**).
   - Practitioners who bill for services that they know are not medically necessary. The maximum civil monetary penalty applicable has increased from the actual cost to up to $10,000 for each occurrence.
3. The HIPAA establishes criminal sanctions for health care fraud applicable to both government and private payers. It adds health care fraud to the criminal code, and defines a federal health care offense as a violation of (or criminal conspiracy to violate) specific provisions of the U.S. Code, if the violation relates to a health care benefit program.
4. New programs have been established to enhance the federal government's ability to investigate and prosecute fraud and abuse:
   - a Fraud and Abuse Control Program under the jurisdiction of HHS to coordinate existing federal, state and local programs that combat fraud and abuse.
   - a Medicare Integrity Program that will contract with outside entities (that may or may not be Medicare carriers) to review the activities of providers who receive Medicare payment - including medical, utilization and fraud reviews.
5. Beneficiaries will be encouraged to report fraudulent activities through an incentive program.
   - The beneficiaries currently contact the Medicare carrier when they feel they did not receive a service that shows up on their Explanation of Medicare Benefits. According to the carrier, the majority of these reports are either due to a misunderstanding of the services listed or incorrect information on the billing (e.g., wrong health insurance claim number or incorrect date of service). You can avoid these "referrals" by educating your patient about the services ordered and billed, as well as verifying the accuracy of the information submitted.

Organized medicine was successful in getting Congress to adopt language to clarify that physicians and other providers can be sanctioned only if the person "acts in deliberate ignorance of the truth or falsity of the information or acts in reckless disregard of the truth or falsity of the information."* It was **not** the intent of legislators to "penalize the exercise of medical judgment of health care treatment choices made in good faith, and which are supported by significant medical evidence or held by a respectable minority of those providers who customarily provide the service. The Act is not intended to penalize providers simply because of a professional difference of opinion regarding diagnosis and treatment."

This is the first time that upcoding has been defined as a fraud and abuse violation that could be subject to civil monetary penalties. However, the "deliberate ignorance" and "reckless disregard" language should protect physicians from being sanctioned for unintentional or inadvertent coding errors or differences of opinion regarding the use of a particular code, since there is a burden of proof that must be established.

Physicians must know and follow the CPT definitions and documentation guidelines. A physician who chooses not to read or follow the CPT definitions may not be protected, because this could be considered deliberate ignorance. Similarly, a physician who ignores repeated notices from a carrier that they are consistently billing a wrong code may not be protected, because this could be considered reckless disregard.

Although the emphasis on fraud and abuse continues to grow, from the perspective of the Colorado Medicare Carrier and a representative of the local Office of the Inspector General, it is not "their" intent to penalize anyone for honest, unintentional mistakes. If you have specific questions, or would like additional information you can contact Marilyn Rissmiller in the CMS Health Care Financing Department at 779-5455 or 1-800-654-5653, ext. 2428.

* As part of this year's Medicare budget process officials of the Clinton administration are trying to remove this language. The AMA has contacted members of Congress regarding this change. Current information on the 1997 Medicare budget proposals can be found on the CMS Web page at http://www.cms.org.

Excerpts were taken from the American Society of Internal Medicine's report on the HIPAA.

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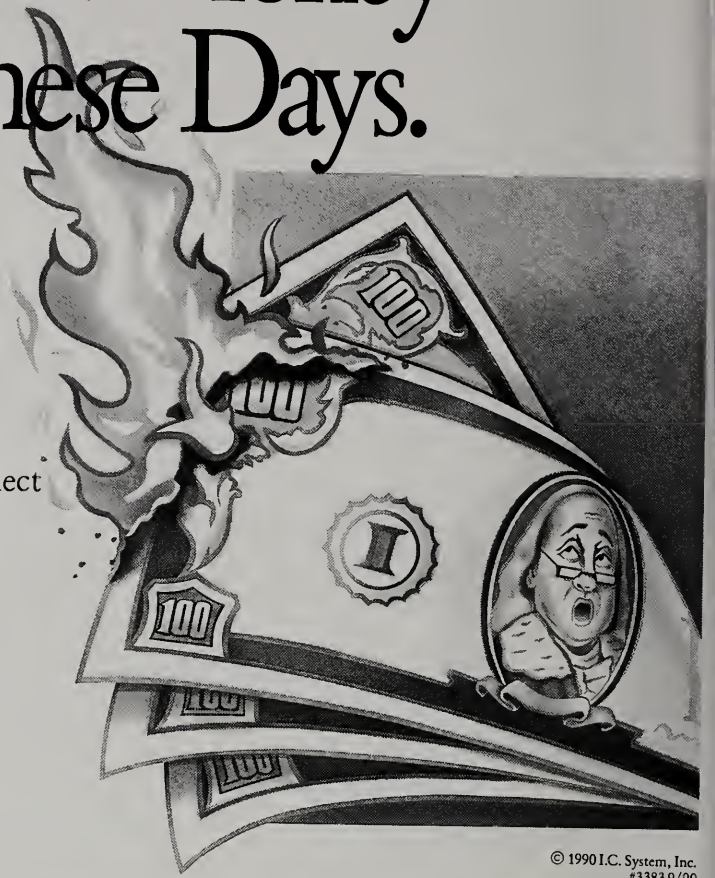
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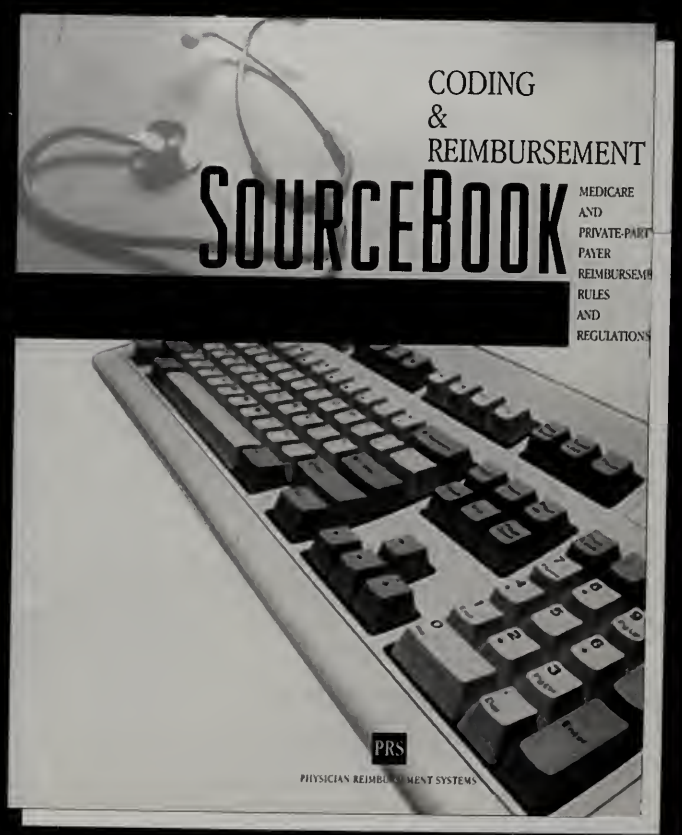
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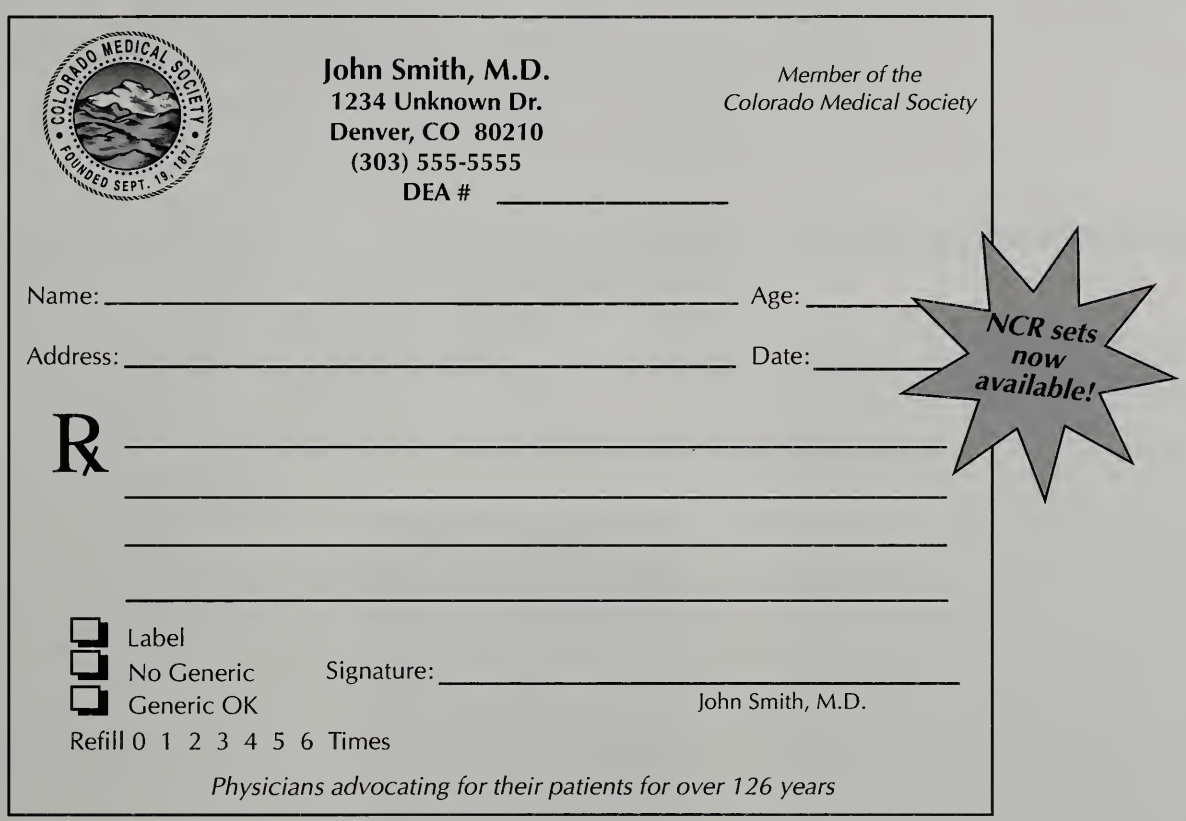
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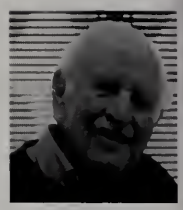
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Order today and let your patients know that you are a proud member of the Colorado Medical Society advocating excellence in the profession of medicine.



by John Lightburn, MD
Historian, Colorado Medical Society

From the Historian:

About two months ago , Gus Garcia and I were enjoying a meal together when the conversation turned to earlier days; Gus started reminiscing about his father, James Garcia, M.D. and his practice in rural Eastern Colorado. I asked him to write an article for this space, and he graciously agreed to do so. Following is Gus's account of his father's life, with a few additions and amplifications.

John Lightburn, MD

A Country Physician on the High Plains

by F. A. Garcia, M.D.

My father, in many ways, was a very unusual individual. He was born east of Pueblo, Colorado, on a homesteaded farm in 1873 and was next to the youngest in a family of five children. His father, Serafin, born in Albuquerque in 1843, migrated north to Colorado where he met Catherine Coffey whose large Irish family was migrating west from the east coast. They married and settled down on the farm east of Pueblo in 1868. Five children came in fairly rapid succession.

In 1875, my grandfather fell into the St. Charles river and died of pneumonia a few days later. He had two draining chest wounds from arrows that had hit him during the Plains Indian conflicts of the early 1860s.

Times were difficult for my grandmother with five children to raise and a farm to take care of. She inspired my dad , James, to go to school in Pueblo which was six miles away. He was an excellent athlete and football player. Alva Adams (later to become U. S. Senator) noticed him and persuaded him to continue his education at the "Normal School" in Greeley (now U.N.C.). He played football there and was graduated in 1902. My father, however, was a man of few words and soon realized that teaching was not his field. So he enrolled in the University of Colorado at Boulder in the School of Medicine. He continued playing football and played on both the University team and the Denver Athletic Club team. He was clear about his priorities! To pay for his continued education, he took time off to work in the gold mines in Cripple Creek as an ore sorter. He finally received his M.D. degree in 1907.

Following graduation, my father set up practice in Ft. Lupton where the Great Western Sugar Company had built a new sugar refinery. He apparently was doing well when he was called to Yuma County where his sister had homesteaded. She had a child very sick with Bright's disease (chronic glomerulo nephritis secondary to scarlet fever). I'm sure he had very little to offer the child. Scientific medicine in those pre-Flexner days was not very good. Physicians did what they could with many non-specific medicines and a lot of compassion and caring. A day extended into a week, then a month, and he started to see the sick farmers and ranchers of the county, becoming committed to a life as a family physician on the high plains. So he moved his practice from Ft. Lupton to Idalia, a small village of about 150 hardy souls.

In 1912 on a cold Christmas day, Ethel Manley, my mother was traveling by sled to her home in nearby Kirk and developed frostbite. She stopped in Idalia to see the doctor there. That is how my mother and father met. They soon married and established a home in Idalia. Their home was primitive with no electricity, no running water or indoor plumbing until well into the 1930s, when the REA finally brought electric power to the rural United States.

High Plains '33

Brown earth, searing sun, incessant wind,
Dust--like powder, hair, eyes, teeth.
A blazing August afternoon,
Popcorn-size clouds far to the west,
billowing, growing.
A boom of thunder, a flash of light,
Small drops growing, growing,
the heavenly smell,
Rivulets running,
The high plains will bloom again!

F. A. Garcia, MD

My early remembrances of the 20s and 30s are many and vivid. Eastern Colorado was a difficult place in which to live --dry land farming, totally dependent on the weather with burning heat in the summer, bone chilling cold in the winter and incessant wind, always blowing. It was a land of boom and bust, and the physician was directly involved. There were boom times before and during the "Great War" when the world needed the food produced by the American farmer. But economic hard times hit the farmers in the early 20s long before the onset of the Great Depression in 1930. In addition, my father was a very poor business person and often said, "These people are my friends! How can I charge them for my services?"

In the early days, James and his wife, Ethel, had a team of sorrel horses, Hans and Fritz, and a buggy in which he made house calls. This was probably better than the Model T Ford that followed. It would never start in cold weather. I can remember pouring hot water in the radiator and on the manifold only to learn that it had a flat tire after we had started the engine. Sometimes I accompanied my father on his house calls. He had a busy obstetric practice, all of the deliveries being accomplished at home. He said the new mothers should stay in bed for several days following delivery. One day I was with him when he made a follow-up visit on a woman he had delivered the day before. As we approached the farm house, we saw her working out in the field. When she saw us in our cloud of dust, she dropped her hoe and ran into the house and was obediently in bed when we entered the house. My father winked at me but sternly rebuked her for not following his orders.

Farm injuries were frequent: setting fractures and dressing wounds all with no IVs, transfusions or antibiotics.

One day I was in his office when a young man was brought in with a serious injury that required a general anesthetic for repair. He handed me the mask and chloroform bottle and instructed me to administer the anesthesia, one drop at a time.

The terrible flu epidemic of 1918 decimated the community. Diphtheria and scarlet fever were common, and lobar pneumonia killed many. In the case of the latter, I can remember open windows, cotton or wool batting vests and a wait of five to seven days for the terrible "crisis" at which time the patient immediately improved or died. I remember another case very well. A childhood friend of mine was diagnosed as having acute appendicitis; surgery was advised, but Denver was a long day's drive over bad roads with transportation that left much to be desired. The child's farmer parents would not consider transporting him. A few days later, they reported that while at school the pain had subsided. They were elated, but my father told them that the appendix had ruptured. Sure enough, a spiking temperature and rigid abdomen followed. In the middle of an eastern Colorado blizzard, the desperate parents elected to make the trip, which must have been frightful. My friend died at Mercy hospital.



Felice A. "Gus" Garcia, MD
President, Denver Medical Soceity
1973

By necessity, the country doctor had to be involved in the community. In the 1910s and 1920s, there was not a high school within 30 miles of Idalia, and the farmers in District 74, many of whom were hard working but stubborn, refused to have a high school in Idalia. My father and six other enlightened citizens put up the money for a three room high school built out on the plains three and one half miles from town.

Following World War I, the farm economy experienced a steady decline, and the farmers in the high plains were ill equipped to survive the terrible drought and dust storms of the 1930s. The dust storms were devastating. The wind howled and the whole sky was a brown color. Even with wet sheets on the windows, there was brown dust everywhere. If the doctor's life was a difficult one, the life of the doctor's wife was even more so with a large family, no financial security and a total absence of anything cultural. There was only those endless dust storms, rolling thunder storms and a flat prairie with hardly a tree in sight and the ever blowing winds. In spite of all this, my mother saw her six children through college.

In 1937, my father finally gave up his Idalia practice, the first and last doctor to practice there. After leaving Idalia, he spent three years as a physician in the Civilian Conservation Corps (CCC) and then he retired.

The rural high plains and Idalia have changed. The Ogallala aquifer has been tapped and the farmers are prosperous. In the last few years, this small community has raised over a million dollars to enhance the consolidated school with a new gymnasium, a day care center, a cafeteria, a large computer room with forty computers and a health clinic with doctors from Wray and elsewhere in attendance.

Impressed by my Father's experience, I wanted the profession to recognize the present day rural family practitioners as durable, hard working physicians who gave much to their community. I recalled a small, bushy tree that survived the harsh environment of the high plains called the Osage Orange. It was one of the few plants that survived the hostile environment of the plains, a suitable symbol of the family physician. From the beautiful hard wood of this small tree, I had a walking stick or cane fashioned, to be presented to a rural family doctor as recognition of outstanding service to the community and to the profession. First to receive the award was Roger C. Shenkle, M.D. of Gunnison and two years later, John S. Tarr, M.D., of Grand Junction received the award.

We all owe a debt of gratitude to these stalwart physicians.

A decade of service:
Off to new adventures



Dr. Bogin is moving on...

After more than a decade of service to organized medicine and health care in Colorado, Robert M. Bogin, MD, is moving. "It's a great adventure, I keep reminding myself of that," he says of his upcoming job in Blue Bell, Pennsylvania as senior editor of Merck Manuals. For those who know Dr. Bogin, such an optimistic statement typifies his character. Genuinely positive, persistent and committed are just a few words that can be used to describe him. Those same qualities are reflected in his work for the Colorado Medical Society. He will be missed.

Dr. Bogin leaves his current position as Vice President and Medical Director of United Healthcare of Colorado. His new position at Merck will tap into his expertise with computers. Merck publishes popular medical textbooks, including the *General Medical Textbook,* and the *Manual of Geriatrics.* He will also oversee the multimedia release of the home version of the general textbook which is due out soon.

Dr. Bogin began his involvement with CMS in the Young Physicians Section. Organized medicine was a "wonderful" opportunity to meet physicians and become more aware of medical needs throughout the state. The experience soon became much more as his commitment grew. His work ethic ushered him quickly through the leadership ranks of the society and put him in the position to assist in the formulation of numerous benchmark policies. Perhaps one of his proudest achievements came when he chaired the Health System Reform Task Force. Under Dr. Bogin's leadership, the newly formed task force helped create many of the policies upon which current legislative reform is based. He went on to sit on the CMS Board of Directors, the COMPAC Board, the Council on Legislation, and the Medical Informatics Committee. For the past five years Dr. Bogin has also been an Alternate Delegate to the AMA.

His commitment to community and patients reflects his dedication to the principles of medicine. Dr. Bogin played an instrumental role in creating the Natural Science Ambassadors Program which promoted science by having doctors speak to school children. His work on the Medical-Legal Clinic won a national award from the American Bar Association. Physicians and lawyers teamed up to provide care and legal services to the underserved at the Stout Street Clinic in Denver. Dr. Bogin was also the medical reporter for 9News for two years and has helped maintain the success of the 9Health Fair.

As his career continues to evolve, Dr. Bogin remains steafast in his commitment to medicine. He will continue to practice once a week and plans on staying involved both at the national level as secretary of AMPAC and at the state level with the Pennsylvania Medical Society. As to his service to the Colorado Medical Society, he is quick to note how proud he is to have worked with the "best society in the federation". CMS wishes him success in all of his new adventures.

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"The materials are effective and practical."
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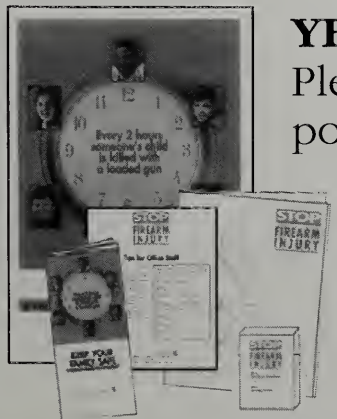
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Medical News

Pat Clark wins the AMA/ Glaxo Wellcome Award

Patricia Clark, a medical student at the University of Colorado Health Science Center, recently received the AMA/Glaxo Wellcome Achievement Award. The award was presented to 25 medical students in recognition of their exceptional leadership abilities in medicine or achievement in community activities at the AMA Leadership Conference earlier this year.



Pat Clark recieves her award from Nancy Dickey, MD, Chair, AMA Board of Directors.

Ms. Clark was recognized for her work as founder of the Rural Health Network, a national network of information about rural health care and training opportunities. She even expanded access to this information by making it available via a world wide web page.

A student leader in CMS, MS. Clark has served on numerous committees– CMS Board of Directors, state chair of the CMS-Medical Student Section, and delegate to the CMS House of Delegates.

El Paso County medical ethics essay contest

The El Paso County Medical Society and El Paso County Physicians foundation recently held their third annual essay contest on medical ethics for junior and senior high school students. Contest winners received prizes of $1,000, $600 and $400. Their schools will receive $600, $300 and $100.

This year students wrote on the ethical dilemmas facing physicians who treat patients that are on death row. First place winner Shruti Badhwar, a junior at Palmer High School, concluded that the ethical debate must be answered by the credo to "always treat the patient regardless of the situation". Erin Phinney, a junior at Palmer High, took second place and Tiffany Anderson, a junior at Air Academy High School won third place. A group of community leaders from health care, law and the media judged the contest.

AMC Cancer Research Center Foundation hires Joel Edelman

Joel Edelman is the new Executive Director of the AMC Cancer Research Center Foundation. The foundation was formed in 1995 to endow the center and its programs of scientific research into the prevention and control of cancer. Edelman will oversee all aspects of gift planning to the foundation.

Mr. Edelman has a strong health care background. He most recently served as Executive Vice President of Frontier Community Health Plans. He was also President and CEO of Rose Health Care Systems for 16 years.

Plains Medical Center named outstanding rural practice

Plains Medical Center, in Limon, Colorado, has won the Outstanding Rural Health Practice Award from the National Rural Health Association. The award recognizes a community-oriented rural health care delivery practice that has improved access for rural people through innovative, comprehensive approaches. Factors taken into consideration include outreach efforts, preventive health and educational programs, quality and efficiency of care, and strong community support and involvement.

Rebuilt in 1993 after a tornado ripped through the town, Plains Medical Center is a private, non-profit organization that provides numerous services including primary care, dental, mental, obstetrical, social and public health services to its regional community of 20,000. Specialty services are available. The clinic also serves as a hub for three satellite clinics.

Plains Medical Center is community oriented, especially when it comes to the development of preventive care programs. Working in conjunction with residents, the medical center has created parenting skills courses and sports physical days that focus on healthy teenage life-styles.

New El Paso County Health Department Director

Dr. Steven Englender is the new director of the El Paso County Department of Health and Environment.

With 20 years experience in public health, Dr. Englender's last position was as director of the Maricopa County Department of Public Services in Phoenix Arizona. He replaces Dr. John Muth, who was director for 16 years. The Health Department has 240 employees and an annual budget of almost $10 million.

Level II Physician Accreditation Seminars

The Colorado Department of Labor and Employment, Division of Workers' Compensation, will present Level II Physician Accreditation seminars on July 25-26 in Denver and in Colorado Springs on September 12-13.

The Level II Accreditation Seminar is a series of lectures and workshops on how to formulate impairment ratings utilizing the AMA's *Guides to the Evaluation of Permanent Impairment.* The seminar is led by specialty experts who also outline pertinent administrative and legal aspects of the workers' compensation system.

The seminar costs $375. To obtain a registration form or for more information please call Sharon Elenburg at (303) 575-8756.

Mountain community domestic violence seminar a success

The conference on domestic violence, held June 5, 1997, in Conifer,Colorado (Jefferson County), was deemed a success by those who attended. " I will look harder, diagnose more, refer more appropriately (offer resources)." Compliments included: "I think your inclusion of the perpetrator issues was very helpful." "I appreciated the blend of legal and medical information. . . ."

Success of the conference was chiefly due to the remarkable collaborative efforts of 13 agencies and organizations which came together to offer expertise to these mountain communities who had asked for help.

Special thanks must go to the following program participants: Mark Johnson, MD, MPH, Director JeffCO Dept. of Health and Environment; Ted Villavicencio, MD, President, Mt. Evans Medical Society; Brad Stubbs, LCSW, AMEND; Heather Kassman, MS, CAC III and Linda Mikow, MA, Family Tree/ Women in Crises; Dave Thomas, District Attorney, 1st Judicial District; George Thomasson, MD, Copic Insurance Company; Kim Feldhaus, MD, Denver Health Medical Center and Jim Willoughby, Jefferson County Sheriff's Department.

Be sure to detach and carry the pocket calendar included in each month's issue of ***Colorado Medicine***. It provides valuable tips and resource information on domestic violence victim assistance.

CU School of Medicine gets big donation from CMSA and Colorado AMA-ERF



From right, a jubilant Dr. Krugman receives checks from Jo Netz and Stella Shanks.

The Colorado Medical Society Alliance (CMSA) and the Colorado chapter of the American Medical Association Education and Research Foundation (AMA-ERF) have teamed up once again to successfully raise a large sum of money for the University of Colorado School of Medicine. Two checks totalling over $15,000 were presented to the school's dean, Richard Krugman, MD. The donation marked the end of another impressive fund-raising year for the Alliance, with a total of $20,791.03 raised.

Dr. Krugman said that the funds would go toward student efforts. Specifically, creating a more student friendly campus by making renovations, increasing student assistance in the rural health scholars fund, and sponsoring student events like the winter ball.

Stella Shanks, President of the CMSA, and Jo Netz, Colorado AMA-ERF Chairperson presented the checks.

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GERIATRICIAN-PACE site in Denver looking for innovative physician to join growing program for the frail elderly. Strong multidisciplinary team, small organization allows freedom practice to obtain goal of maintaining the elderly at home instead of nursing homes. BC, FP or IM. CAQ in Geriatrics. Fellowship a plus but not necessary. Competitive salary; great Rocky Mtn lifestyle. Contact Willie Orr, Total Longterm Care, 3204 W. Colfax Ave., Denver, CO 80204 or call (303) 573-8123. 03/0497

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LARGE MEDICAL GROUP associated with one of Colorado's top integrated health care systems seeks BC/BE family practice physicians. Excellent multiple practice opportunities in Metro Denver and surrounding areas. Fax CV to (303) 595-6156, mail to Physicians Services, Centura Health, 4231 W. 16th Ave., Denver, CO 80204, or cal (303) 629-4026. EOE 03/0797

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FT.LUPTON/KEENESBURG, COLORADO Dynamic family practitioner needed to join a rural team of one FP and two FNPs. Physicina wil practice at the Ft. Lupton Clinic on alternative days (20 minutes apart). Call will be 1 in 4.

Physician will be employed by large hospital located 30 miles north. Full benefits package including salary, incentive plan, CME's, health, dental, etc. These rural communities are located one half hour northeast of Denver.

Send CV to: Sherry Kozero-Roth, Physician Services, 1801 16th Street, Greeley, CO 80631; Phone (970) 350-6786. 03/0597

SOUTHERN COLORADO BC/BE Internist to join 3 Internists in rural non-profit primary care group in Alamosa, located in high desert valley surrounded by mountains. Outdoor activities abound. Contact Michael Firth, MD or Marguerite Salazar @ (719) 589-3658. 02/0797

STERLING, COLORADO – Rural Northeast community is seeking BE/BC family practitioner with OB skills to join a busy family practice group in a new, attractive, and fully equipped building adjacent to a 36 be regional medical center. The departure of a physician has created an opening and the cnadidate will assume a full load of patients. Currently two physicians and two FNPs staff the practice.

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Sterling Regional Medical Center's medical staff consists of 30 physicians, a number of midwives, and serves a population of 25,00. It is located 2 hours northeast of Denver and offers hunting, boating fishing, and a golf course.

Send CV to: Jan Mesar, PO Box 830, Loveland, CO 80539-0830: Phone (970) 635-4036. 03/0597

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RUMINATIONS

(**def:** chewing again what has been chewed slightly and swallowed; to **REFLECT**)

*by **Bill Pierson**, Managing Editor*

"It's music to my ear." What does it mean?

It hurts me to think about it. Just the thought of what some people do to their children that they might enjoy the vicarious thrill of being... or doing... We've heard a lot about this subject since the December tragedy in Boulder, Colorado. But the subject is nothing new. This rumination brings to mind the 17th century practice of "castrato:" the act of castrating a boy or young man so that his voice will remain at a pure soprano or contralto tone for as long as possible. Why? So the boy/man could be of a unique singing voice to please others. This may have been an act of the gelded person's own volition, but musical history says it was often the choice of a parent who had a child so changed for life, and the child had no "voice" in the matter.

Now that **really** hurts to think about. The practice reminds me of what we do to animals for the "pleasure" of humans. Typically, the gelding of an animal to remove much of the animal's vitality and spirit, to make him more useful in a specific human-use role.

Imagine in the first scenario... a child given no say in what his parents or others might do to him, just so those adults can preserve that moment in their lives. By doing so they stopped the development of that child dead in the body's most natural phenomenological path. That's a horrible thought. I am thankful that the practice was halted many years ago.

All this brings to mind what psychologists have said for years: the human species reacts to music in a variety of ways. There are huge mood swings brought on by music. Music has been used for centuries to incite specific responses among people. Music carries with it the ability to create mental pictures... each human reacting in a different and individual manner to the sounds.

When I speak of how humans react to music I am reminded, too, of an experience early on in my own communication career: I had the opportunity to work with a voice coach from the New York Metropolitan Opera. I learned from her that the "spoken" word can be considered in the same vein as the "lyrical" expression, thereby adding a quality to speech that is more pleasing to the ear. When you consider this view (from an operatic perspective) it is not difficult to understand. Like them or not, operas take ordinary human verbal communication and lyricize, giving the speech much more emotional expression.

Poetry is very similar in its ability to draw out the deepest human emotions in the listener (when effectively recited). Poetry is, in a great sense, music.

We have all heard or used the expression, "It's music to my ear". What does it mean? Simply - the sound, the thought, the meaning, is highly pleasing. There's no reason that daily human verbal communication cannot create much the same reaction. And yet we allow our lives to become so pressurized that every sound is an invasion of our "space," every voice becomes strident and grating. Few people honestly think before they speak, caring little about the effect they have on the listener. One exception is when an automobile driver cuts off another automobile in a lane change. Listen to the "offended" driver if you want to hear stridency. He/she leans on the horn and then somewhere, to himself silently, or at maximum lung power, he/she usually screams (often profanity) at the other driver. No longer can he respond with any civility. We have boiled it all down to the very simplest form possible, no more bothering to consider the other's needs or feelings. (It's obvious the offender needs some training, and he/she usually feels sheepish about getting caught cheating.) This is generally not a time when the speaker is trying to be pleasing to the other's ears, and there's little consideration for lyricism. It's more along the lines of "You g____ d____ no-good m____ f_____ fool! Are you trying to kill us both?" Or some other insult to motherhood, etc. He/she is probably thinking more along the lines of making the offender a **"Castrato"** right there on the spot (gender-applicable).

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"Advocating excellence in the profession of medicine"

ugust, 1997

Volume 94, Number 8

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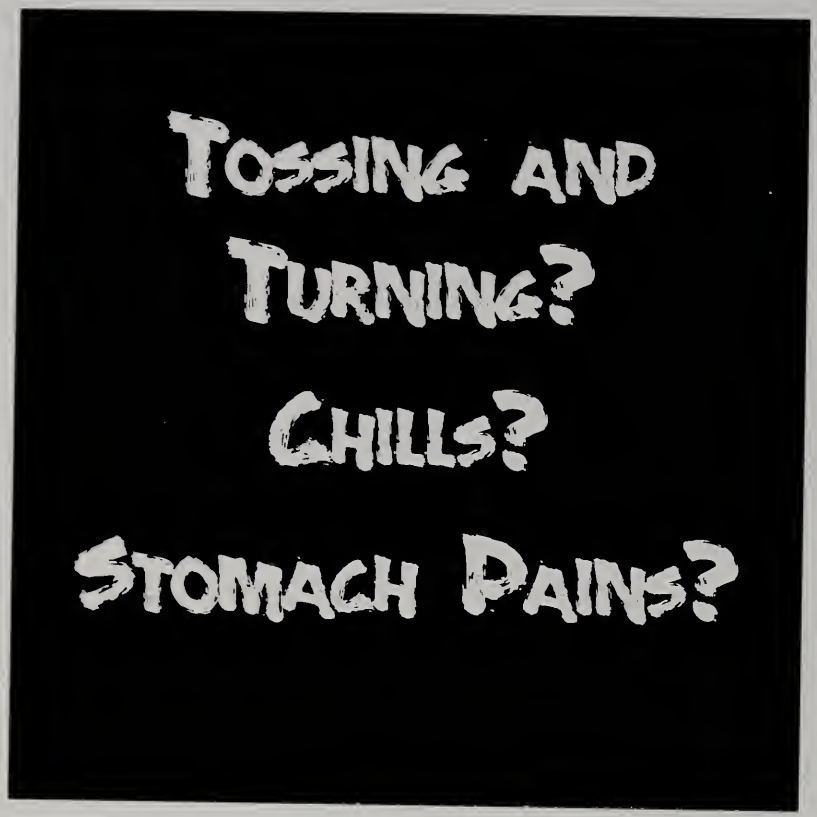
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Annual Meeting Issue

September 12-14, 1997, Snowmass, Colorado

In This Issue:

1997 CMS Elections: The Candidates ..... page 284
Let Seniors Beware ..... page 298
Watch your wallet: Lost/Delayed Insurance Claims ..... page 300
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Cover Story

Community health takes center stage when CMS returns to the popular Snowmass area for the society's 127th Annual Meeting.

See pages 289-293

Cover Photo by Beth Crusha

DEPARTMENTS

277 President's Letter
279 Colorado Physician's Network
281 AMA Update
288 Membership Snapshot
302 Copic Comment
303 CMSA
306 Member Services
308 Archives
311 Medical News
312 Classifieds
314 Ruminations

In This Issue...

277 **Physician Advocacy** – some think there is a conflict of interest, while others believe that CMS should do more. Professionalism and physician advocacy are not mutually exclusive.
M. Ray Painter, MD
President, Colorado Medical Society

284 **1997 CMS Elections** – a number of positions will be filled during the upcoming Annual Meeting. The candidates speak their minds.

296 **Homeopathy** – a primer on this often misunderstood alternative medical practice.
Dennis Kay, MD and Nicholas Nossaman, MD

298 **Let seniors beware** – some of your elderly patients are prime targets for fraud, exploitation and neglect. Here's how you can help.

300 **Pocketbook issues** – CMS responds to member claims of lost/delayed insurance claims.

306 **Physicians Financial Program** – an exclusive member service of CMS, find the answers to your financial practice questions.
David P. Halsch

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Sandra L. Maloney, Executive Editor; William S. Pierson, Managing Editor; Chet Seward, Administrative Asst.

Member, Colorado Press Association, Member, Colorado Broadcasters Association



M. Ray Painter, MD
President, 1996-1997

Physician Advocacy

Actually, I prefer to refer to the "physician advocacy" role of CMS as physician representation and support. I used the term "physician advocacy" to elicit a response. Physicians usually respond to this concept in one of two ways. Either they are very negative, saying things like, "That would be self-serving, unprofessional!" "CMS cannot do the job," "We need a union!" Or they are very positive stating, "Physicians need more support and direction," "CMS should be our advocate," "If CMS doesn't do it, who will?".

Professionalism is not unique to medicine. There are many others in the same category - attorneys, dentists, veterinarians, academics, architects, engineers, etc. Yet, the profession of medicine is singular in that the client (our patient) is placed first, even before the self interest of practitioners - in some cases to the detriment of the "profession". This is one of the reasons I am proud to be a physician!

However, professionalism and physician advocacy are not mutually exclusive. There are many functions that CMS could provide to meet the needs of physicians without compromising its position as a strong patient advocate. Moreover, in some cases, what's good for the patient is good for the physician.

Physicians who feel we should be strong patient advocates are also concerned about being labeled as "self-serving". Some believe that CMS is particularly imprudent in attempting to legislate the preservation of our income. I agree! Strong positions and legislative initiatives attempting to maintain our earnings will fail, tarnish our image and damage our effectiveness.

However, there are many actions that CMS can take to meet the needs of physicians that are unrelated to payment issues and will not hurt us in the eyes of the public. CMS currently provides many services including coding, third party payment support, managed care oversight, legislative representation, forums for discussion of issues by other physician organizations, and assistance in defining "turf" or scope of practice.

Physicians need direction and support as the health care system transitions from a physician controlled service industry to a free market, Wall Street controlled "big business." The business of medicine is becoming too detailed, precise and complicated for the average physician or group of physicians to run successfully. Witness the trend that many physicians have ineffectively contracted with managed care, or observe the fact that many of us leave 20 percent of our income on the table because of an improper understanding of payment rules or incorrect coding. On the other end of the fence, many of our members are moving into administration, entrepreneurial or salaried positions. The question is what do Colorado physicians need, and how can CMS play a role in providing for that need?

We have a choice. CMS can assist physicians or we can leave this function to private businesses and

(Continued next page)

"Professionalism and physician advocacy are not mutually exclusive."

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(**President's Letter** cont.)

specialty groups. Other state societies have successfully assisted physicians with specific practices, business support (e.g. contract review, practice audits, practice management), and education regarding business issues. They have served as informational sources on business issues and some have formed service organizations to provide practice management. The list goes on...

I think CMS should move forward, take the actions necessary to fulfill physicians' needs. CMS could provide the initiative, direction, and support needed to enhance physicians' position and strength in the new business world in which we are forced to function. CMS has an excellent track record of launching successful businesses to fulfill specific needs of the profession and physicians - CFMC, COPIC, CPN, to mention a few.

What do you think? What role should CMS play? What functions or services should CMS provide? What role should CMS play in assisting you in the decisions you must make about your practice future? Should CMS encourage, initiate or joint venture such business support?

Speak up! This is your organization. CMS will follow and act on your direction. My dad always said, "Be careful what you wish for...you might get it!" If you want nothing, say nothing.

Write to me at P.O. Box 17550, Denver, CO 80217, or FAX (303) 771-8657.

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Legal Update

from Gelt, Fleishman & Sterling P.C.



A. Craig Fleishman, Managing Director

Changes to Subchapter S Corporations

As a general rule, a subchapter S corporation is not separately subject to federal income tax; instead, its shareholders are taxed on the net income of the corporation. The benefit of this taxing regimen is that earnings of the corporation generally are subject to only a single level of income tax.

Recent legislative changes have expanded the use of subchapter S corporations as tax planning devices. Those legislative changes include:

- an increase in the number of permitted shareholders of a subchapter S corporation from 35 shareholders to 75 shareholders;
- the permitting of subchapter S corporations to have subsidiaries that are both subchapter S corporations and subchapter C corporations (note that the net earnings of subchapter C corporations *are* separately subject to federal income tax;
- the permitting of banks that do not employ the reserve method of accounting for bad debts to elect subchapter S status;
- the permitting, after December 31, 1997, of certain charitable entities and certain pension, profit sharing, and stock bonus plans to hold stock in subchapter S corporation;
- an expansion to two years of the time that a trust of a decedent may hold stock in a subchapter S corporation;
- the creation of a new type of trust, i.e. an electing small business trust, that is permitted to hold stock in a subchapter S corporation.

If you would like to learn more about the new tax planning techniques available through the use of subchapter S corporations, please contact:

Gelt, Fleishman & Sterling P.C.
1600 Broadway, Suite 2600
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CMS Med Fax®

...a compilation of medically-related news briefs of immediate interest to the physician community occurring after ***COLORADO MEDICINE*** has gone to press. ***AT PRESS TIME...***

CMS Med Fax®
by Montgomery Little and McGrew, P.C.
legal counsel to the Colorado Medical Society

CMS to hold Drug Formulary Forum

In response to member concerns regarding managed care formularies the Colorado Medical Society will hold a Drug Formulary Forum during the upcoming CMS Annual Meeting in Snowmass on Saturday September 13, 1997 at 1:30 pm to 3:30 pm.

Under the auspices of the CMS/Colorado HMO Association Joint Committee, the Formulary Study Group has been formed to address various issues related to drug formularies. A major goal of this group has been to address RES-57-P, AM '96, *Formularies used by Managed Care Organizations*. This resolution was written to make formularies more user friendly and uniform. As a result of the ongoing process, Pharmacy Directors from major Colorado HMOs have agreed to present a program to discuss: the formulary process, development, contracting, expectation, compliance, trends, claims processing, drug utilization review edits, and overview of CMS/Colorado HMO Association Formulary Study Group Project

There will be time allowed for questions following the program.

Doctor, this is your opportunity to learn more about drug formularies. This will also be a great opportunity to ask questions and share information regarding drug formularies and how they affect your practice.

Please plan to attend. If you have any questions, call Edie Register at CMS. Telephone: 1-800-654-5653 or 1-303-779-5455 ext. 2421.

Legislative interim committees address no-fault insurance and intractable pain

A legislative interim committee has been established pursuant to HJR97-1043 charged with studying the high cost of mandatory motor vehicle insurance in Colorado, the success of No-Fault Insurance programs and to consider what methods may be used by the state to reduce such costs. Recent legislative proposals which have *not* been enacted have focused on creating a verbal threshold, increasing the catastrophic threshold from $2,500 to $50,000, establishing a relative value medical fee schedule for PIP and the creation of an Insurance Consumer Advisory Panel. It is expected that medical costs under PIP will receive a significant amount of criticism by the insurance industry. Interestingly, according to the Division of Insurance, the percentage complaints with respect to auto insurance regarding high costs is 9% compared to 23 % regarding denial of claims.

The Intractable Pain Interim Committee will be meeting in September to discuss legislation enacted in the 1997 legislative session and any follow-up recommendations concerning those bills. The four legislative proposals adopted earlier this year: 1) Mandate that an insurance carrier disclose any limitations or exclusions to coverage of treatment of intractable pain (if the plan is silent on the issue of coverage, coverage may be presumed); 2) Allow a pharmacist to accept a verbal order for schedule II drugs for Hospice patients in emergency situations (to be followed by a written order); 3) Clarify that a physician is not subject to disciplinary action by the BME solely for prescribing controlled substances for the relief of intractable pain; and 4) Calls for medical malpractice insurers to grant premium discounts or other incentives to physicians who obtain continuing education in the assessment and treatment of pain. The committee is also expected to review recent developments in the medical establishment concerning chronic pain management.

The CMS Government Relations Department is closely monitoring these committees.

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Med Fax: Medico-Legal News

by Karen B. Best, Esq., an associate with the law firm of Montgomery Little & McGrew, P.C.

This column contains information concerning topics of general interest in the medical-legal field. For further information or help with specific problems, please contact Montgomery Little & McGrew, P.C.

Medicare/Medicaid: Fifty ways to commit fraud and abuse

Whenever I read about fraud and abuse in the Medicare/Medicaid system I'm reminded of Simon and Garfunkel's song about fifty ways to leave your lover. But fifty ways probably doesn't begin to cover all the ways used to defraud the system. The following are some of the recently reported cases concerning fraudulent claims, although they certainly aren't the most creative.

Take for example, Dr. Krizek, a psychiatrist in Pennsylvania who treated Medicare/Medicaid patients. The federal government claimed that between January 1986 and March 1992, Dr. Krizek, with the assistance of his wife who kept his billing records, submitted 8,002 false or unlawful reimbursement requests for services that were medically unnecessary, and had been "upcoded"; that is, Krizek allegedly used the code for 45-50 session ("90844:), when Krizek actually saw the patient for only 20-30 minutes. IN some cases, Krizek claimed to have worked more than 24 hours a day. The court found that a 9-hour workday was a reasonable daily schedule, and ruled that Dr. and Mrs. Krizek should pay civil penalties of $5,745,000. They were penalized for each of the 264 days he allegedly billed more than nine patient-treatment hours, or twelve 90844 claims, and fined for each of the 8,002 allegedly false claims. The case was appealed, and ultimately sent back to the trial court for a recalculation (and reduction) of the civil penalty.

In a somewhat similar case from Montana, HCFA found that the Great Falls Eye Surgery Center billed Medicare for overlapping CRNA services, sometimes adding up to 27 hours for the services of a single CRNA in a ten-hour workday. The jury was instructed that it could convict the Center and its owner and medical director, Dr. Erickson, if it determined that they "adopted an attitude of willful blindness" and "kept themselves deliberately ignorant" of Medicare billing regulations. Dr. Erickson was convicted even though he was not involved in the billing procedures and was not actually aware that they were illegal.

Dr. Tencer and Dr. Lazar, licensed chiropractors in Louisiana, had another plan. Dr. Tencer allegedly turned over most of his practice, Allied Chiropractic Clinic, to Dr. Lazar so he could supervise the clinic's financial affairs. From 1988 to 1992, Tencer and Lazar allegedly paid patients' insurance premiums, in return for which patients signed multiple sign-in sheets indicating they had received treatments in the office. Patients testified that Tencer also instructed them to lie to insurance representatives about their health. The sign-in sheets allegedly were used to generate false claims. Tencer was tried and convicted of a number of counts including conspiracy, money laundering, and mail fraud, was ordered to forfeit $700,000, sentenced to 78 months in prison, fined $17,500, and ordered to pay restitution of about $452,000. Lazar, similarly convicted, was sentenced to 33 months imprisonment, and fined $30,000. Portions of the conviction were overturned on appeal.

It almost goes without saying that these individuals were also banished from the Medicare/Medicaid provider roles. The last reported case concerning Dr. Erickson had him appealing a 15 year suspension. It is a wonder how people who seem to be so smart will throw away so much for so little.

Send us your calender items.

If your specialty society or hospital is sponsoring a CME event or seminar which would be of interest to physicians in Colorado, have them send the information to: Event Calender, *Colorado Medicine*, P.O. Box 17550, Denver, CO 80217-0550. Please include information detailing program sponsor, date, location and phone number for more information.

CMS Med Fax

1997 Fall Clinics

Physicians from Colorado and several neighboring states will gather inMontrose to participate in the 26th Annual Montrose Fall Clinics on September 26 and 27, 1997. The Fall Clinics are sponsored by the Montrose Memorial Hospital and its medical staff.

These guest speakers will present various medical topics during the meetings which will be held at the Montrose Pavilion, 1800 Pavilion Drive.

Registration will begin at 8:00 a.m. on Friday, September 26, with lectures throughout the day, and from 8:30 a.m. through 12:30 p.m. on Saturday, September 27.

Scheduled to speak at the clinic are:

- Randrll W. Burt, M. D., Professor of Medicine, University of Utah School of Medicine, Chief, Division of Gastroenterology, University of Utah HealthSciences Center, Salt Lake City, Utah

- Norman A. Kaplan, M. D., Professor of Internal Medicine, Head, Division of Hypertension, The University of Texas Southwestern Medical School, Dallas, Texas

- Story Musgrave, M. D., NASA Astronaut, Lyndon B. Johnson Space Center, Houston, Texas

- Eric vmSonn(mbarg, M. D., Chairman and Professor of Radiology, Professor of Internal Medicine and Surgery, University of Texas Medical Branch, Galveston, Texas

- William C. Watars, IV, M.D., Director, Acute Dialysis Services, Piedmont Hospital, Clinical Associate, Emory University School of Medicine School of Medicine, Atlanta, Georgia

Topics discussed at the Clinic will be:
"Colon Cancer Screening c Polyp Management";
"Genetics of Colon Cancer for the Clinician";
"Management of Mild Hypertension";
"The Difficult to Treat Hypertensive";
"An Artist's View of the Universe";
"Medical, Physiological & Psychological Aspects of Space Walking";
"New Techniques in Interventional Radiology: Something for Almost everyone";
"Cryotherapy: A Cool Tool to Treat Cancer and Other Disorders";
"Firearms and Violence";
"The Challenge of Treating Obesity".

Interesting case presentations will be discussed at the end of Saturday's program by the participants as well as the guest speakers. In addition to the medical lectures, participants will have the opportunity to visit over 50 pharmaceutical displays by various drug companies. These provide the physicians the opportunity to discuss new products and techniques with the company representatives. Eleven hours of Category I AMA credit will be given to those attending the clinic.

The Annual Fall Clinics Awards Banquet and dance will also be held at the Pavilion on Friday evening. Music will be provided by The Ghost River Band. The post conference retreat on Saturday will be held at the Story's summer home at Trout Lake above Telluride, Colorado.

Persons who would like further information on the clinic may contact Kathy Holman at the hospital, 970-240-7397.

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Colorado Medical Society provides the following listings of events as a member service only. Some events are approved for Continuing Medical Education credits. Information is provided by the sponsoring organizations. For more details, use the telephone contact at the end of the listing.

The International Skeletal Society 24th Annual Refresher Course
September 10-13, 1997
Santa Fe, New Mexico
(770) 641-9773

The Given Institute
Quandries in Health Care: Decision making, moral ambiguity and motivation
September 18-20, 1997
Aspen, Colorado
(970) 925-1057

Denver Medical Library
Informatics Fair '97: Computers in the physician's office– overcoming the obstacles
September 25-27, 1997
Denver, Colorado
(303) 839-6670

American College of Cardiology
14th Annual Santa Fe Colloquium on Cardiovascular Therapy
September 25-27, 1997
Santa Fe, New Mexico
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Colorado Hospital Association
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October 24, 1997
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American College of Cardiology
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Snowmass, Colorado
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American Lung Association
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March 25-28, 1998
Big Sky Montana
(406) 442-6556

First Colorado Electronic Data Interchange (EDI) Conference for physicians and office managers

Leading Colorado healthcare payers and electronic data interchange (EDI) and billing companies are jointly sponsoring "Healthcare EDI Colorado – Into the Next Millennium." The conference will be held on Thursday, August 28, 1997, at the Colorado Convention Center in Denver from 9:00 am until 3:30 pm.

The purpose of the one-day conference is to focus attention on existing and cutting-edge products, services, and programs for healthcare providers to demonstrate ease of use and flexibility.

Participating sponsors in this conference are CIGNA Healthcare, Clinic Services, Electronic Data Submission Systems (EDSS), Mountain Medical Affiliates (MMA), Paramount Health Services (physician-owned network), QualMed/Foundation Health Systems, Inc., BlueCross BlueShield, Sloans Lake Managed Care and The Alliance.

Highlights of the program include:

- **Keynote address by Leland Kaiser, Ph.D.**
- **EDI panel presentation**
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Colorado Physician Network, Inc.

Choice Clips



by David M. Martz, MD
President CPN

Rocky Mountain Physicians Choice is no longer just a vision of what might be. Nor is it merely a statewide panel of physicians hoping for patients to treat. We have now enrolled our first purchasers, and patients are already being treated by our members. With initial marketing efforts focused on the southern front range, the eastern plains, and the northwest, we are finding an enthusiastic response in several of these communities. Canon City, Alamosa, Limon, Burlington, and Craig are among the communities where we are growing rapidly. As of July 1, 1997, we had over 1600 enrollees, and by the time this goes to press and reaches you, we are likely to have well over 2000 on board! Of the current 1637 participants, 1308 are group contracts, 14 are individual, and 315 are Medicaid. Although these numbers are not yet large, we have been actively marketing only a few months and entirely in small communities. Remember that RMHMO itself has over 95,000 members, and thus we are associated with the 4th largest HMO in the state of Colorado. Although there are 21 licensed HMO's in the state, only FHP, Kaiser, and Blue Cross exceed RMHMO in enrollment.

We believe our growth will be enhanced as we work on restructuring premium rates to be more competitive, enlarge our primary physician panel (especially in the Colorado Springs and Pueblo region), intensify our broker relationships, and focus our marketing methods. All of these issues areunder intense scrutiny at the present time, as we prepare to enter the Denver metro market in the months ahead.

Note that our annual meeting will be held on August 23, 1997, at 9:00 a.m. at the Holiday Inn, Denver Southeast. Mark it on your calender now and plan to be there, as we will provide an in depth update on the state of our organization and allow ample time for interactive dialogue.

We are off and running, and gaining momentum every week. As we savor this long awaited first taste of reality, we must now move forward quickly to prepare the larger feast which awaits us--and the people of Colorado who await the arrival of managed care done right!!

AMA Political Grassroots Conference

The American Medical Association is (AMA) will a Political Grassroots Conference on September 17-18 in Washington, D.C. Physicians are encouraged to attend to learn about legislative and regulatory issues affecting patients, physician and the American health care system. Grassroots support and strength are skills that organized medicine must preserve. To register call 1-800-621-8335.

At press time Sandi Maloney was on vacation. Her column, "Executive Director's Update", will appear next month.

Here's Our Agenda

It's simple. It's straightforward. And it represents the future of medicine. The American Medical Association presented to the Republican and Democratic leadership this agenda for the upcoming 105th Congress. Your AMA membership strengthens our voice in support of physicians and their patients. . . and will enhance our efforts to turn these goals into reality.

- **Patient Protections** Above all, preserve the ability of physicians to act as advocates for their individual patients. Do not allow insurers to "gag" physicians or withhold medically necessary treatments from their patients.

- **Medicare Reform** Make the Medicare program solvent. Expand patient choice of plans. Allow future growth rates that cover patients needs. Retain special protection for the vulnerable and elderly.

- **Medical Education and Research** Continue to support medical education and research so we can find cures for killers such as AIDS and cancer.

- **Public Health Problems** Expand prevention and treatment programs to combat AIDS, drug abuse, smoking and violence. These problems cost billions of dollars and millions of lives.

- **Liability Reform** Enact meaningful liability reform to ensure fair compensation to patients with legitimate claims while eliminating excessive malpractice awards that lead to defensive medicine.

Join or renew your membership in the AMA today — call 800 AMA-3211

American Medical Association

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1847 • 1997

AMA Update



Richert E. Quinn, MD
Senior Delegate, AMA

The American Medical Association House of Delegates met from June 22 to June 26, 1997, in Chicago. As usual, a wide variety of issues were addressed through multiple reports from the Board of Trustees and from the various Councils and through literally hundreds of resolutions submitted by delegations and individuals. Two other events "colored" the proceedings; during the House of Delegates' meeting Dr. James Todd, former Executive Vice President of the AMA, expired at age 65. At the same time that the House was grieving over the loss of this wonderful leader, we were "celebrating" the 150th anniversary of the Association.

Several debates highlighted this meeting. Certainly the most controversial and contentious issue had to do with the subject of late-term abortion. Shortly prior to the meeting, the AMA Board of Trustees had announced support on a piece of Federal legislation that would ban and criminalize the so-called "partial birth abortion." The House endorsed the Board's special report on this subject, which had called for severe restrictions on the procedure that it described as "intact dilatation and extraction." Several specialty societies and the American Medical Women's Association vigorously argued against the position that the Board had taken. The Colorado delegation heard from many of our constituents on both sides of this issue. Ultimately, the House backed an amendment that instructed the Board to continue to press on both Federal and state levels to eliminate criminal penalties in similar legislation. Opponents of the Board's position repeatedly expressed reservations about endorsing a bill that might subject a physician to a criminal penalty and about intrusions into medical decision-making and the physician/patient relationship. Ultimately, the House voted to support the actions of the Board of Trustees, perhaps at least partially because of the political "risk" that might be associated with a change in the AMA's position relative to this issue on Capitol Hill.

The issues in this debate were potentially deeply divisive for the Association, and the manner in which advocates on both sides conducted themselves was exemplary. Certainly, the Board heard criticism of their handling of the situation along with the support that was exhibited. Their position was, and remains, one in which they defend their actions by stating that the legislation will be better and less damaging to the medical profession than if the AMA had not taken a position.

The House of Delegates voted to continue to fight in Congress for a one year delay in the government's proposed practice expense rule for Medicare reimbursement. This reaffirmed the policy set at last year's interim meeting of the House of Delegates. The AMA also request that the new values be based on the actual resources involved in the provision of physician services.

The government's proposed system, scheduled to become effective January 1, 1998, would increase practice expense payments

(Continued next page)

"The issues in this debate were potentially deeply divisive for the Association, and the manner in which advocates on both sides conducted themselves was exemplary."

(**AMA Update** cont.)

for services performed in the physician's office and reduce reimbursement for procedures done in the hospital. This would result in rather drastic cuts for some surgical specialties and increases for primary care practitioners. The family physicians opposed deferring implementation for another year, but have demonstrated a willingness to compromise in the name of unity of the medical profession. The debate over the validity of the methodology that HCFA uses to compute direct and indirect practice expenses remains controversial. Coupling this possibly "flawed" methodology with a change to a single conversion factor might result in cuts in reimbursement in some specialties that would be so drastic as to threaten access for Medicare recipients. In this climate, most parties feel that a gradual roll out or phasing in of the practice expense regulation would be best.

The House of Delegates called on the American Medical Association to work to "remove restrictions for physicians to form collective bargaining units in order to negotiate reasonable payments for medical services and to compete in the current managed care environment." This reflects continued desire on the part of physicians to be able to band together to negotiate in the managed care environment, but results in the American Medical Association continuing to be pitted against the Justice Department and the Federal Trade Commission who hold that joint negotiating by independent physicians violates Federal anti-trust law. Underlying this discussion is the debate about the effectiveness of doctor unions. Approximately 20,000 physicians nationwide currently belong to unions, many being residents who are employed by hospitals.

The AMA has established a new Division of Representation to pursue these issues, but does not express optimism about any dramatic breakthroughs in the near future, given the intransigence of the governmental authorities.

The American Medical Accreditation Program survived several attempts by specialty societies and some individual states to scale back its magnitude and continues on schedule with initial implementation in several states occurring later this year. The basis for increasing support seems to be a general acknowledgment that such an accreditation program is better run from within the medical profession than by other organizations based outside of organized medicine.

The House did approve overwhelmingly AMAPs five components: credentials, personal qualifications, environment of care, clinical performance, and patient care results.

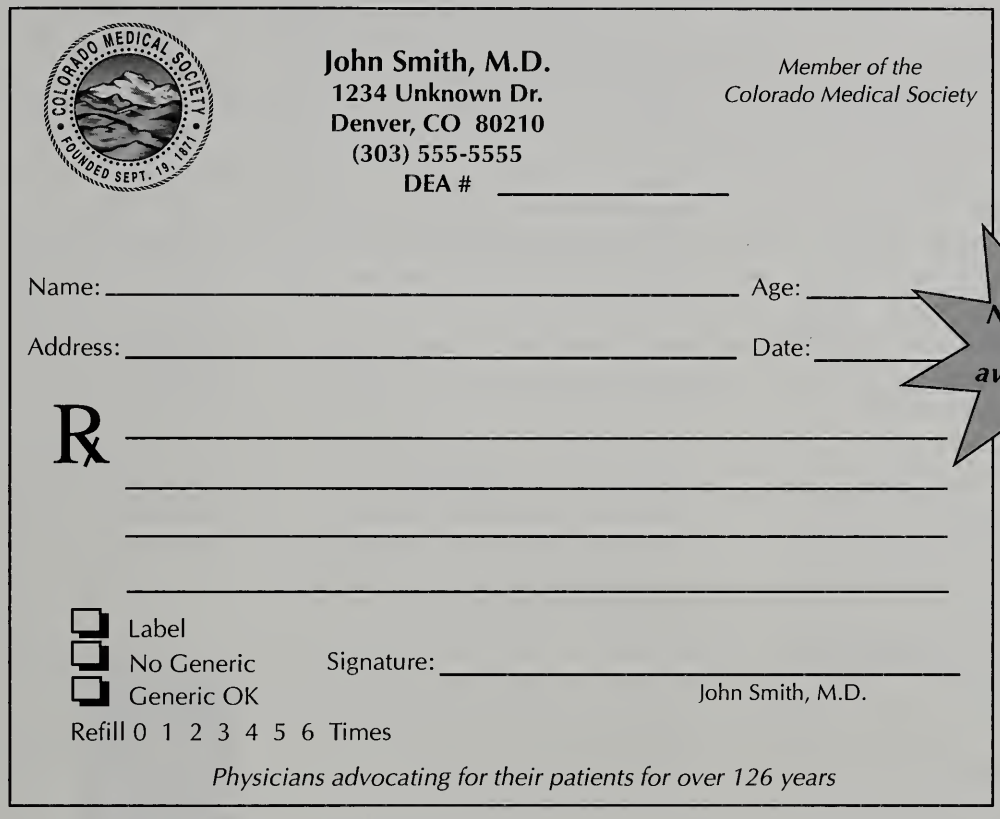
A report that was approved by the House of Delegates would have the AMA oppose laws requiring physicians to report cases of domestic violence. This was based on existing policies that recommend the importance of protecting the confidentiality of the physician/patient relationship and the right of competent adult patients to determine their own course of treatment. This position contrasts with Colorado state law, as enacted last year. The AMA, in its report, did endorse state efforts to implement anonymous public health reporting systems for surveillance of allviolence and abuse.

In an issue related to an extensive debate that took place during previous sessions of the AMA House of Delegates, the Supreme Court found unanimously no constitutional right to assisted suicide. This represented a victory for the AMA, as the court cited the "Amicus" brief filed by the AMA and 51 other medical groups. The court found a critical distinction between refusing life-sustaining treatment and taking active steps to end life, and accepted medicine's claims that was possible to alleviate pain in the dying patient. Nonetheless, the court did acknowledge that some states are involved in serious, thoughtful examination of the issue, and the court made it clear that it was leaving the door open to a different conclusion in the future if, for example, pain control proved to be elusive in certain cases.

Your Colorado delegation continues to achieve recognition at a national level. During this session of the House of Delegates, Dr. Mark Levine chaired the reference committee dealing with the late-term abortion issue and was widely lauded for the way he conducted these hearings. Dr. Richard Allen was re-elected to the Council on Medical Education. We have lost one of our most effective members, Dr. Rob Bogin, who recently moved to Pennsylvania. An election will be held at the Colorado Medical Society House of Delegates to replace Rob as an alternate delegate. I believe we would all like to express our thanks to Rob for the excellent work that he has performed on behalf of the Colorado Medical Society at the AMA level over the past ten years. Going forward, we are going to have some exciting announcements about future campaigns on the part of members of our delegation. We do feel that we are effectively representing the physicians of Colorado.

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Order today and let your patients know that you are a proud member of the Colorado Medical Society advocating excellence in the profession of medicine.

1997 CMS Elections:

Candidate statements

Elections will be held for various leadership positions during the upcoming 1997 Annual Meeting of the Colorado Medical Society House of Delegates. Elections will be held for the following CMS offices: President-elect, Speaker of the House, two Delegate positions to the American Medical Association (AMA) and two Alternate Delegate positions to the AMA. The following are brief statements by candidates.

Candidates for President-elect

Donald G. Eckhoff, MD



The mission of our society is to advocate for high quality patient care. Unfortunately, our focus as a medical society and as individual physicians is often shifted from this singular goal by the economic realities of contemporary medical practice. Managed care has focused our attention on cutting the waste and inefficiencies from our practice to contain cost. Managed care has caught us in a web of contractual arrangements and incentives that divert our attention from the quality of care. As a society, we need to acknowledge these economic realities of medicine, but our goal must be to focus attention on quality of care and advocate for excellence in the profession of medicine.

I believe the Colorado Medical Society can accomplish its mission by taking the following four steps:

- advocate for the Medicare beneficiary who is loosing access and benefits as HCFA tries to contain the cost of a system facing insolvency;
- advocate for the underinsured whose access to health care is becoming more tenuous;
- recommit the society to data collection and analysis (outcomes) as a proven method of ensuring quality of care and help standardize a set of validated data collection instruments;
- establish a state-wide computer network to provide physicians the timely information they need to render high quality care.

I believe I am qualified to lead our Society in the pursuit of its mission because I have been a member of the Colorado and Denver Medical Societies since 1982, holding the offices of President and now Chairman of the Board of the Denver Medical Society, as well as serving on the Colorado Medical Society Board of Directors for the past six years. I have earned these positions of trust through participation in numerous committees, task forces, community service projects and legislative efforts on behalf of both societies. I am a practicing Orthopædist. I have spent several years in private solo and group practice before moving to my present practice location at the University of Colorado Health Sciences Center and Denver Veterans Affairs Medical Center. Direct patient care comprises two thirds of my practice, while teaching and research in outcomes and health policy encompass the balance of my time.

I ask for your help to take the four platform issues addressed above from the forum of presidential debate to front and center stage of the Colorado Medical Society agenda over the next two years. With your support, I am confident we can anticipate the future, develop creative solutions, and nurture change while maintaining our roots in the traditional practice of medicine, i.e. quality patient care.

W. George Shanks, MD



My parents brought me from Scotland to the United states when I was a wee boy, whereupon we settled in Philadelphia. After I completed medical school, my wife and I arrived in Denver for my postgraduate training. We have been in Grand Junction for the past 21 years, where I am in the private practice of General Surgery. We have four children: Maggie Anne, an OR nurse at Denver General; Bradley, an architect in Denver; Fiona, a college student on the East Coast, and Lorna in her first year of high school. I have always been a strong supporter of organized medicine. I am a former president of the Mesa County Medical Society and have served on the Board of the Colorado Medical Society for the past four years, where I currently hold the post of Treasurer. My wife, Stella, is currently the President of the CMS Alliance and is a former president of the Mesa County Medical Society Alliance.

It is my opinion that the Colo-

rado medical Society has always maintained and should continue to maintain its role as physician advocate. Although the technological advances in medicine in the past few years have seen a meteoric rise, the role of the physicians, if anything, has diminished. If I am, as many have suggested, a "health care provider", why do I spend all of my time with unhealthy people? Why do I spend my days in the hospital OR and ICU rather than the health spa. The answer is, I am a physician, and my whole being revolves around treating and comforting the infirm.

Although the maintenance of good health and the prevention of illness are worthwhile goals that we should all strive to achieve, there are plenty of maladies that continue to need our immediate attention.

Today, the CMS needs to focus primarily on the issues that will enhance the physician's ability to be a physician. The goal should be a well trained physician in a setting where both the patient and physician want to be, and where the only deliberating revolves around what is best for that individual patient.

We physicians have always been the patient's advocate and will continue to be. However, unless we establish a strong, meaningful physician advocacy, I fear the health of the physician is what will be in jeopardy.

I would be most grateful for your support of my campaign for President of the Colorado Medical Society. You have my pledge that I will do everything possible to bring honourable recognition to our profession, which it so richly deserves, while striving to ensure that patients in Colorado receive the best possible health care, which they also deserve.

Speaker of the House



Louise McDonald, MD

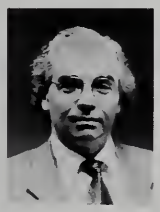
I was looking forward to another few years of apprenticeship under the expert guidance of Speaker of the House of Delegates, Ted Lewis, before assuming those duties myself, but that's apparently not in the cards. Much to my chagrin, Ted has announced that he will not seek another term as Speaker, and so here I am.

When I visited the various delegations at the 1995 CMS Annual Meeting to ask for your vote as a candidate for Vice Speaker, I pledged to work for "continuous quality improvement" of the work of the House and for better communication between Delegates and their constituents, the CMS membership. In order to achieve those goals, the Speaker and I have revised the *Primer* for new CMS members and the *Procedures of the House of Delegates,* and we have instituted an orientation session for new (and "old") Delegates and Alternates at the Annual Meeting. Last year we distributed a survey on House of Delegates proceedings and communications to the 49 other state medical society Speakers and Vice Speakers across the US. We received 27 replies to the questionnaire and many pearls of wisdom on how to run our own House, as well as the pitfalls to avoid.

Several weeks ago Ted and I convened a Task Force of the House of Delegates to study and advise us about our procedures. Task force members described various means of improving our communication with the Delegates, and we will be putting their suggestions into effect before this coming Annual Meeting.

I believe in a strong, active, "user friendly" House of Delegates which serves as a forum for ideas and input from all CMS members. I believe in a House of Delegates that determines policy for the Colorado medical Society through effective representation of all of our membership. In 1995 I said that I also believe the Speaker and Vice Speaker have a year-round job. I have worked year-round in the Office of Vice Speaker and will continue to do so as Speaker. I would appreciate your continued support.

Delegate to the AMA



Mark A. Levine, MD, is a candidate for re-election as Delegate to the AMA.

A board certified internist from the Arapahoe Medical Society, he has been active in CMS affairs for many years. He served on the CMS Council of Socio-Economics for 10 years, chairing the council from 1985 to 1990. He also chaired a reorganizational task force in 1995-96, and is currently a member of the Managed Care Task Force. He has been Parliamentarian of the CMS House of Delegates since 1994.

Dr. Levine is an Associate Clinical Professor of Medicine at UCHSC, and active in health services research through the UCHSC Department of Preventive Medicine and Biostatisitics. He is a frequent guest lecturer at the University of Denver and presents regularly at conferences on topics of managed care, clinical quality, outcomes and data coordination. His commitment to Clinical Quality Improvement is demonstrated by many years of service to the Colorado Foundation for Medical Care where he is currently Vice President and President-elect.

During his 20 years of practicing general Internal Medicine in south Denver and Englewood, Dr. Levine served for five years as Chief of the Department of Medicine at Swedish Medical Center, and was Medical Director for Front Range Medical Management. He is now Vice President and Medical Director for Health Decisions in Golden.

During his tenure as AMA Delegate from Colorado Dr. Levine has served on three reference committees, chairing one, and served as a member of an expert panel on Clinical Practice Expense. He is a member of the Colorado Division of Insurance's Committee on Health Plan Benefits and former chair of the Colorado Health Forum.

Dedicated and experienced, Dr.

(Continued next page)

(**Candidates** continued)

Levine would welcome continue service to Colorado's physicians through re-election as Delegate to the American Medical Association.

M. Ray Painter



As one of your AMA Delegates, I have made valuable contributions to the success of the Colorado delegation on many issues, e.g. patient control of insurance. In addition, having developed considerable expertise in coding and reimbursement in the last ten years, I have been able to represent physicians in this arena, including authoring several important resolutions. I have stood fast on many concepts and practices traditionally important to physicians, and I would like to continue to represent Colorado for another two years.

Alternate Delegate to the AMA

Jeremy A. Lazarus, MD



It was my privilege to serve CMS as Alternate Delegate to the AMA at the June 1997 meeting and I am asking for your support to be re-elected to that position.

Medicine is facing challenges from internal and external forces. The leadership brought to the AMA from Colorado has already brought important direction to our colleagues in the AMA. Our main challenges, as I see them, continue to fall into three general areas:

1) Advocacy for patients unencumbered by untested, non-medical market forces

2) Maintenance of the profession of medicine through the fair treatment of physicians based on science and ethics; and

3) Active participation from organized medicine and leadership in the health affairs of the nation without undue or principle burden for societal priorities on the backs of physicians.

For the past 25 years I have been working within organized medicine both locally and nationally to make certain that those challenges will realized. My activities in CMS have varied from the Council on Legislation, Task Force on Scope of Practice and the Ethics Committee. I have been active in the Arapahoe Medical Society as Delegate to CMS and member of the Physician Advocacy Committee. I am currently on the Board of Directors of the Colorado Physicians Network. I have extensive national experience through my specialty society in the areas of ethics, managed care, legislative and litigation committees and am currently Speaker of the Assembly of the American Psychiatric Association. I am in private practice and am Associate Clinical Professor at UCHSC. I have lectured around the country and have a good sense of where practicing physicians as well as academic and research programs are moving.

The future of medicine depends on our sticking together to foster the three challenges above. I pledge to continue to represent you and all of CMS in pursuit of those goals. Please allow me the opportunity to continue to serve you.

M. Eugene Sherman, M.D.

Picture not available

I am seeking nomination for the position of AMA Alternate Delegate.

My background as an active participant in my component society, my many years as a delegate to the CMS House of Delegates, and my two years as Chairman of the CMS Managed Care Task Force provide me with a varied background for this position. I have actively represented the CMS before the Colorado legislature, and I feel my unique experiences with managed care in this state allow me to represent that most important aspect of Colorado medicine at the AMA level. I have extensive background in hospital-medical staff affairs as well. I am a member of the faculty of the University College, Denver University; my areas of expertise include integrated delivery systems and managed care.

I am eager to serve CMS in the capacity of AMA Alternate Delegate, and I welcome your support for my nomination to this position.

Robert A. O'Dell, MD

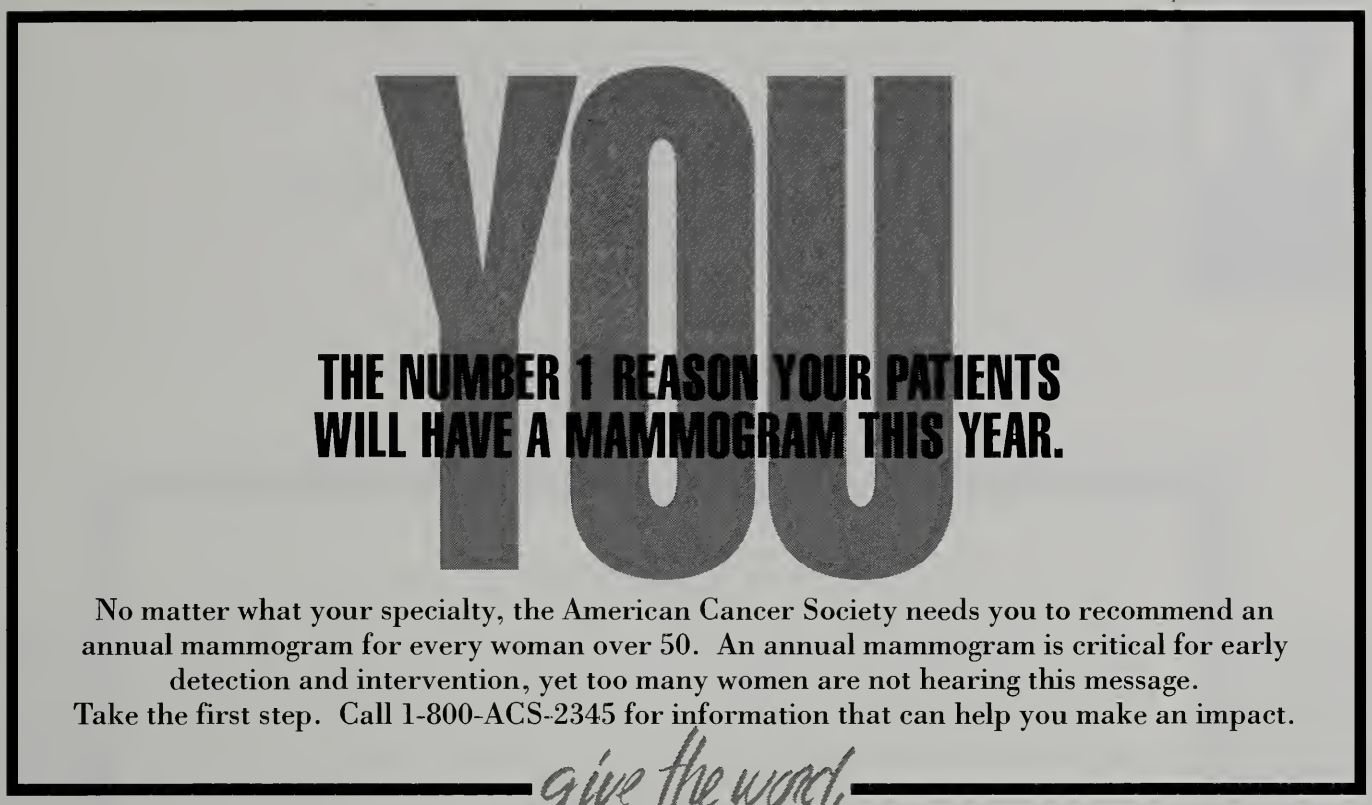


I would like to be the fourth Alternate Delegate to the AMA. After moving out of Colorado in the early 1990's, my wife and I returned in 1994. Since then I have continued in the clinical practice of medicine, part-time, and have renewed my active membership in the Aurora-Adams Medical Society. I am again an alternate delegate to the CMS house. My dossier is not as impressive as those of other candidates, but since I work part time I do have time for AMA affairs. I am interested in encouraging the AMA members to be active concerning several items.

I hope they will oppose: 1) legislation controlling physician prescription of antibiotics; 2) needle exchange programs; 3) legalization of marijuana; and 4) physician assisted suicide.

I hope they will support: 1) efforts encouraging all patients to sign a living will; 2) support of hospice care for the terminally ill, including provision for adequate pain control procedures or medication; 3) nationwide licensure and accreditation; 4) a limitation on the number of appeals available to felons sentenced to death; 5) voluntary castration when requested by habitual sex offenders; 6) the removal of cigarette vending machines; 7) an increase in tobacco taxes to support medical care of tobacco related diseases; and 8) mandatory HIV testing of all pregnant women.

I would appreciate your vote. Thank you.



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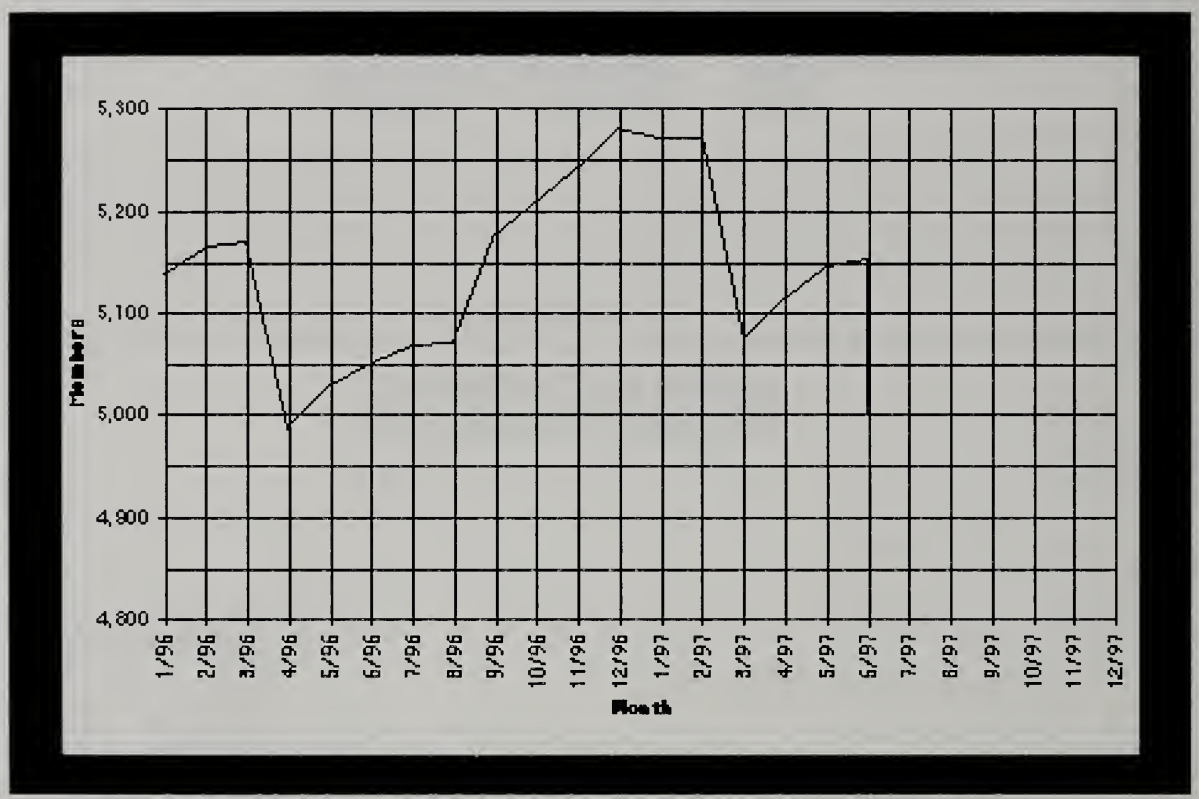
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Membership Snapshot

of the **Colorado Medical Society**
January, 1996, to July, 1997



Total membership of the Colorado Medical Society from January 1, 1996, to July 1, 1997.

What does this snapshot mean? Let's look at the several and various indications of the organization makeup .

First of all, the membership grew to its greatest number in December, 1996, but then a decline hit. The decline, however, can be explained more simply than the increase. Each year, Colorado Medical Society (CMS) purges its membership list of those who have, for whatever reason, not paid dues or have dropped by the wayside during the previous year. This purging accounts for the decrease in our records every year in February, March and April. Most years the drop corrects itself when the physician members are reminded that they will not be included in that year's ***"Medical Office Resource Book"*** (which includes current membership listing).

Each year the CMS Membership and Communications Divisions join forces to mail a survey letter to every member to determine their desires in the current year's ***"Medical Office Resource Book".*** Our membership list begins to correct itself and by June or July those delinquent members have changed their ways.

Currently there are 5,153 members of CMS, of which 4,039 are Active members, 305 Residents and Students, and 809 Dues-exempt (primarily Active Emeritus) members..

Is the CMS member population aging at about the same rate as the general public? Is there a shift in the interests in specialty practice? Are there noticeably fewer solo practitioners? Later this year we will look at the membership by specialty and other demographic measuring sticks. We'll try to produce some answers to these and other interesting questions about you and your fellow physician members.

Our "snapshots" are just one of the tools the CMS leadership and staff use to stay abreast of member needs.

Colorado Medical Society
ANNUAL MEETING EDUCATIONAL PROGRAM
Saturday, September 13, 1997
Snowmass Conference Center

Orchestrating Community Health ... Composed and Conducted by Physicians

This year's educational program will be directed by Joseph Bujak, MD, and Linde Howell. Both are well known health care experts. Dr. Bujak is also keynoting the opening session of the House of Delegates. Ms. Howell is currently Vice President of Janus Healthcare Consultants, Inc., a health care consulting firm specializing in strategic planning, community health assessment and improvement, community-wide disease management continuums, community partnerships, business development, and network design. She has developed a nationally recognized model for assessing and improving community health, as well as a model and training program for community health champions. She has been a national leader in the area of healthy communities, health promotion, and community-wide demand management.


Dr. Bujak


Linde Howell

8:30 a.m.-8:35 a.m. **Overture** –*Gary VanderArk, MD*

8:35 a.m.-10:05 a.m. **First Movement**
Leadership Through Service – *Linde Howell/Joe Bujak, MD*
Commitment to service is the very reason physicians entered the practice of medicine. This session will focus on learning strategies to develop a service oriented culture within your practice and your personal life and the professional and economic advantages of such. Topics include:
1) Power of service
2) Translating Hippocrates - looking at a historical perspective of service and personal activity on practicing medicine
3) Personal panel of service development - looking at specific traits and service capability
4) Future search activity on leadership
5) Service team activity

10:05 a.m-10:30 a.m. **Break**

10:30 a.m.-12:00 n. **Second Movement**
Building a Community Health Symphony with Physicians as Conductors –
Linde Howell/Joe Bujak, MD
The Healthy Community Movement has been initiated most often by hospitals nationwide. Learn how medical group initiated project and participation offer specific personal and professional advantages.
1) Explanation of general systems theory and relationship to physicians and community
2) Community health and necessary components for efficient medical practice
3) Changing healthcare environment and impact on practices
4) Design a Community Health Symphony using learning from GST and Howell/Bujak presentation

This program is sponsored in part by educational grants from the Copic Insurance Company and The Doctors Company.

COLORADO MEDICAL SOCIETY
AND COLORADO MEDICAL SOCIETY ALLIANCE
1997 Annual Meeting Schedule

Snowmass Conference Center/Silvertree Hotel, Snowmass Village
September 12-14, 1997

Thursday, Sept. 11

8:00 am-	CMS Office open
7:30 am-	18-hole Golf Tournament
1:00 pm- 2:00 pm	Finance Committee
2:00 pm- 5:00 pm	Board of Directors
4:30 pm- 8:00 pm	Registration open
6:00 pm- 7:30 pm	Welcome Reception
7:30 pm-	Dinner on your own

NOTE: Dress for Annual Meeting

Thursday evening reception ....
Friday: ..... casual
Saturday morning: ..... casual
Saturday inaugural dinner/dance: coat-tie/dressy business attire or cocktail dress
Sunday: ..... casual

Friday, Sept. 12

7:00 am--	CMS Office opens
7:00 am-- 5:00 pm	Registration
7:00 am-- 7:45 am	Reference Committee Breakfast
7:00 am-- 7:45 am	New Delegate Orientation Brkfst
7:00 am-- 7:45 am	AMA Delegation Forum Brkfst
8:00 am- 12:00 N	Exhibits open
7:45 am-- 8:00 am	Credentials Committee
8:00 am-- 8:30 am	Opening Session House of Delegates
8:30 am-- 9:30 am	Alliance Continental Breakfast- all CMSA members
9:00 am-- 9:30 am	Alliance BOD Meeting
8:30 am- 12:00 N	General Membership Meeting
9:30 am-- 9:45 am	Coffee break
9:30 am- 12:00 pm	Alliance Celebrate Membership Meeting
12:15 pm- 1:45 pm	COMPAC/CMSA Luncheon
2:15 pm-- 3:15 pm	Copic Risk Management
2:15 pm-- 3:15 pm	Copic Risk Management
2:30 pm-- 4:30 pm	Reference Committee
3:30 pm-- 5:30 pm	Reference Committee
3:45 pm-- 4:45 pm	Copic Risk Management
3:45 pm-- 4:45 pm	Copic Risk Management
4:00 pm-- 7:00 pm	Exhibits open
5:30 pm-- 7:00 pm	Exhibitor Reception
6:30 pm-- 8:00 pm	Women in Medicine Dinner and Business Meeting
6:30 pm-- 7:30 pm	Colorado Society of Internal Medicine Annual Meeting
7:00 pm-- 9:00 pm	Gone But Not Forgotten Dinner (by invitation only)

Saturday, Sept. 13

7:00 am-	CMS Office opens
7:00 am- 11:00 am	Registration
7:30 am- 8:20 am	Prayer Breakfast
7:30 am- 8:20 am	Educational Program Continental Breakfast
7:00 am- 11:00 am	Exhibits open
8:30 am- 12:00 N	Educational Program
12:00 N- 1:30 pm	Copic LTC Benefit Q&A Lunch
12:00 N-	Recreation Time - golf, tennis, horseback riding, biking, fishing, walking, etc.
1:30 pm- 3:30 pm	Drug Formulary Forum
1:30 pm- 4:30 pm	Copic Seminar
5:00 pm- 6:00 pm	Primary Care Physician Caucus
5:30 pm- 6:15 pm	Meet the Candidates Reception
6:15 pm- 7:00 pm	Inaugural
7:00 pm- 10:30 pm	Presidents' Dinner/Dance
9:00 pm- 10:30 pm	Copic Dessert Reception

Sunday, Sept. 14

6:30 am-	Reference Committee Reports available
7:00 am-	CMS Office opens
7:00 am- 10:00 am	Registration
7:00 am- 8:30 am	Component Caucuses
	Arapahoe
	Aurora-Adams
	Boulder
	Clear Creek Valley
	Denver
	El Paso
	Larimer/Weld
	Pueblo/Western Slope
8:00 am- 8:30 am	Credentials Committee
8:30 am- 12:00 N	Closing Session HOD
9:00 am- 10:00 am	CMSA Gavel Club Breakfast
12:00 N (or immediately following HOD)	Reorganizational Board Meeting



Joseph Bujak, MD, FACP, to keynote Annual Meeting



Renowned health care futurist, Joseph Bujak, MD, FACP, will be the keynote speaker at the 1997 Annual Meeting of the Colorado Medical Society. Dr. Bujak will focus on the major dynamics transforming the health care industry and how they are impacting physicians. He will critically assess the way physicians currently approach patient care, and examine the factors that cause an absence of health in populations. What's at stake for you as the tactical forces of health care continue to change, what is your business, and what is it that you value both professionally and personally? Difficult questions and challenging answers will be explored as Dr. Bujak engages you in determining if there is a better way.

Dr. Bujak currently serves as Vice President, Medical Affairs for Kootenai Medical Center, Coeur d'Alene, Idaho, and VHA's Mountain States region. A dynamic speaker, he understands the stabilizing role of positive vision and strongly held values. He works toward developing leadership and followership, especially in the physician community.

CMS Annual Meeting Golf Tournament

at the Snowmass Club Golf Course
Thursday, September 11, 1997
Entry Form

Name _____

Address _____

Please give us the following information for tee times and emergencies

Office Phone _____ Home Phone _____ FAX# _____
(necessary for reservations)

While in Snowmass I will be staying at _____

I will be attending the meeting in the capacity of (check one)

❑ Physician ❑ Exhibitor ❑ Spouse ❑ Other

I will: ❑ Sponsor a golf course hole @$100 ❑ Sponsor a putting green contest hole @$50

Name of sponsor (as you wish it to appear on sign) _____
(Professionally made signs will be displayed for sponsors.)

My golf handicap is _____ or my average score is _____

Please reserve a set of ❑ **Left handed** ❑ **Right handed** clubs for me. I will pay the $30 rental fee on site.

If you would like to play please return this entry form as soon as possible because space is limited. ***CMS has reserved tee times, starting at 7:30 a.m. for only eight foursomes.*** Play will be scramble format. Foursomes will be arranged according to various levels of ability by the golf professional. If you have a preference of who you are teamed with, please specify below. Prizes will be awarded for a variety of categories to include closest to the pin and longest drive. To ensure tournament entry, registration form and advance payment of $95 must be received **no later than** August 21, 1997. Cancellations received after August 21, 1997 are refundable subject to ability of Snowmass Golf Club to "resell" vacated tee times.

You will be notified regarding tee times. A shotgun start will not be possible, therefore, please be prompt with your tee times. To reserve other personal tee times, please call the Pro Shop at (970) 923-5600.

I prefer to be teamed with _____

* Mail Entry Form and check to Barbara Campbell, 2251 Ash Street, Denver, CO 80207. Make checks payable to Barbara Campell. For additional information please call Barbara Campbell at (303) 388-5307

Colorado Medical Society
Annual Meeting
September 12-14, 1997

Snowmass Resort Association
P.O. Box 5566
Snowmass Village, CO 81615
Phone (970) 923-2010
1-800-598-2004 FAX (970) 923-4260

If reservations have already been made directly with the hotel, please do not send this card. To make reservations by mail, please complete the following and mail to the address above. To guarantee these special rates, ***reservations must be received by August 28, 1997.***

Name _____

Name(s) of additional person(s) sharing room: (# of adults _____ # of children _____)

_____

Address _____

City _____ State _____ Zip _____ Phone ( ) _____

Arrival date _____ Departure date _____

Please reserve the following: (Special rates apply from September 9-17.)

❑ **Silvertree Hotel Lodge Room** ($113 per night for 2 persons, each additional $25)

❑ **Wildwood Lodge Room** ($100 per night for 2 persons, each additional $25)

Silvertree Dbl.	**$113 + tax**
Wildwood Dbl.	**$100 + tax**
Check-in Time:	**4:00 pm**
Check-out Time:	**11:00 am**

Payment type–Personal check or major credit card may be used to secure deposit. One night's lodging required.

Type of card _____

Card # _____ Exp. Date _____

Name of Cardholder _____

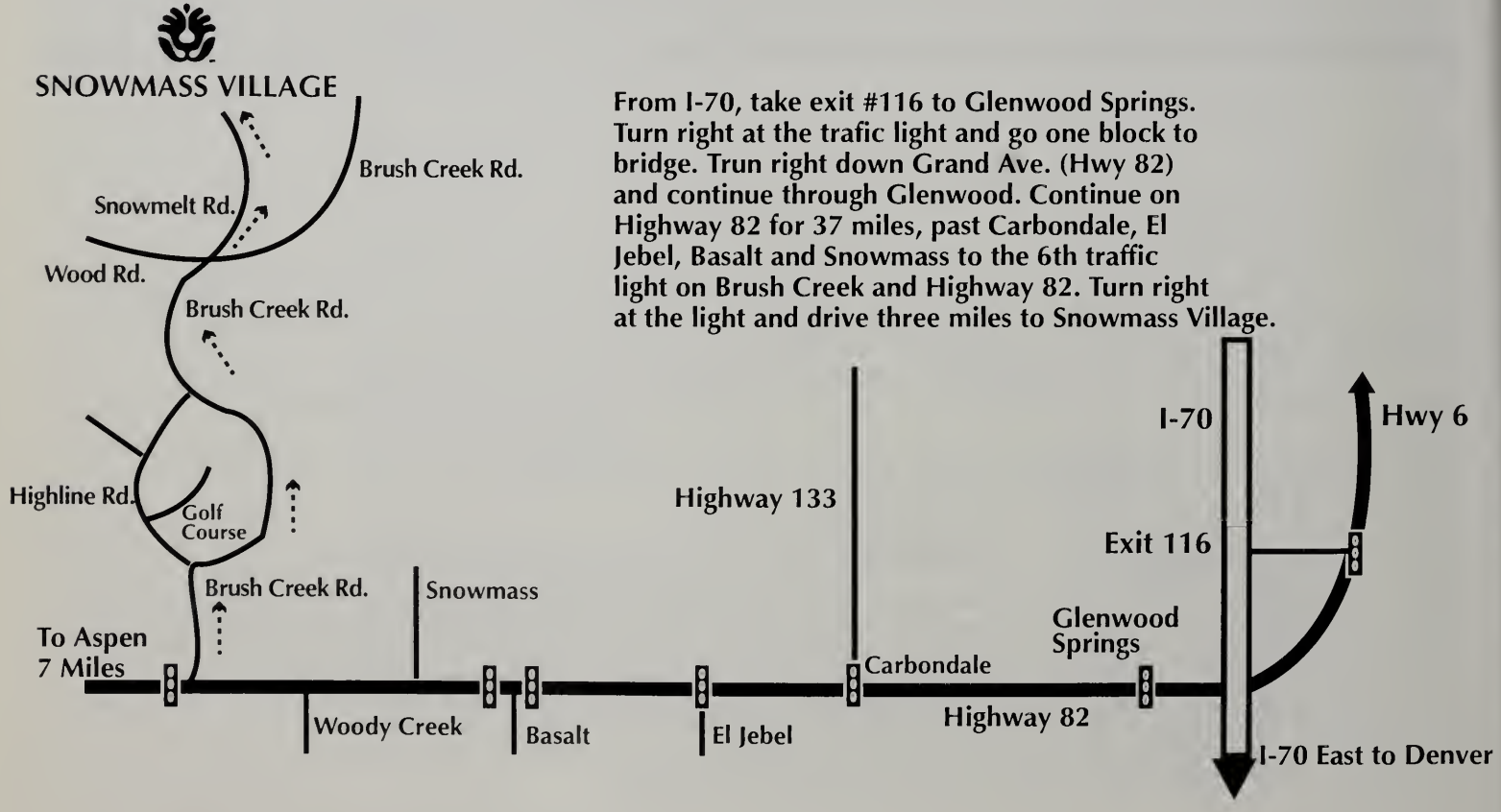
"I authorize Snowmass Central Reservations to charge my credit card for the deposit and prepayment for accommodations listed above."

Signature _____ Date _____

Children 12 and under stay for free in parent's room with existing bedding. Current sales tax is 11.5% (subject to change). CANCELLATION POLICY: If cancellation occurs 14 days or more prior to arriaval, there is a 10% handling fee. If cancellation occurs less than 14 days prior to arrival, deposit is forfeited unless room is re-rented. If re-rented, full refund will be made, less 10% handling fee.

Please let us know how we may accommodate any disability or special request.

GETTING TO SNOWMASS VILLAGE



From I-70, take exit #116 to Glenwood Springs. Turn right at the trafic light and go one block to bridge. Trun right down Grand Ave. (Hwy 82) and continue through Glenwood. Continue on Highway 82 for 37 miles, past Carbondale, El Jebel, Basalt and Snowmass to the 6th traffic light on Brush Creek and Highway 82. Turn right at the light and drive three miles to Snowmass Village.

Annual Meeting Registration

1997 Annual Meeting of the Colorado Medical Society and CMS Alliance
September 12-14, 1997, Snowmass Conference Center, Snowmass Village, Colorado

Name (please print) _____

Component Society _____ Names of Spouse/Guest(s) (if attending) _____

If you are not a member of CMS, please provide the following:

Company/Organization _____ Title _____

Reservations for Events and Meetings

Reservation deadline is August 29, 1997. (Note: To attend the President's Dinner Dance on Saturday, you **must obtain** your tickets before noon, Friday, Sept. 12.) Reservations accepted on a first-come, first-served basis (may be limited for some programs). For purposes of registration, staff of county medical societies are considered members. You must indicate the number of attendees for each function so that we may be cost efficient with food/beverage orders.

As a member, ***you and one guest are entitled to attend the complimentary events at no charge.*** Please indicate the number of additional guests at the bottom of this form and enclose your check.

Complimentary events open to all members: Please indicate below which functions you will attend.

THURSDAY, SEPTEMBER 11			
6:00 pm	Welcome Reception	member ❑	guest ❑
FRIDAY, SEPTEMBER 12			
7:00 am	New Delegate Orientation Breakfast	member ❑	
7:00 am	AMA Delegation Forum Breakfast	member ❑	
7:00 am	Reference Committee Member Breakfast	member ❑	
5:30 pm	Exhibitor Reception	member ❑	guest ❑
SATURDAY, SEPTEMBER 13			
7:00 am	Educational Program Continental Breakfast	member ❑	guest ❑
8:00 am	Educational Program	member ❑	guest ❑
7:00 pm	President's Dinner Dance: (Please select menu from below)		
	Beef and Chicken Dinner	member ❑	guest ❑
	Vegetarian Dinner	member ❑	guest ❑
	Vegan Dinner	member ❑	guest ❑
9:00 pm	Copic Dessert Reception	member ❑	guest ❑

Additional Reservations (other than member + 1 guest):

Educational Program Breakfast	# _____	@$15 each=	_____
President's Dinner Dance (**Reservations necessary**, please select menu below)			
Beef and Chicken Dinner	# _____	@$50 each=	_____
Vegetarian Dinner	# _____	@$50 each=	_____
Vegan Dinner	# _____	@$50 each=	_____

..... Total for Additional Reservations $ _____

Non-Complimentary Events:		**Cost**	**Number**
FRIDAY, SEPTEMBER 12			
12:15 pm	COMPAC/CMSA Luncheon	$20 each	_____
	..... Total for Non-Complimentary Reservations		$ _____

Total enclosed for non-complimentary and/or additional reservations ..... $ _____

After completing this form, please mail it to: CMS, P.O. Box 17550, Denver, CO 80217-0550, or FAX it to CMS at (303) 771-8657. For questions, please call (303) 779-5455 or 1-800-654-5653 ext. 2419.

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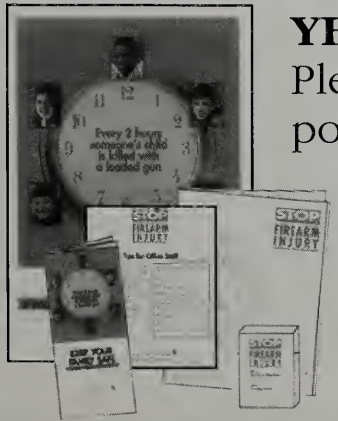
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Office or Clinic Address

City State Zip

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Homeopathy:
What you need to know

by Dennis Kay, M.D. and Nicholas Nossaman, M.D

"...a substance which produces a particular pattern of symptoms in a normal person will cure the same pattern of symptoms in a sick person."

Abstract: Homeopathic medicine is a science of heaiing that has been in existence for two hundred years. Although it has been used more widely in other countries around the world, its use and acceptance continues to grow in the United States. Homeopathic medicines stimulate healing. These medicines are highly diluted and energizied substances. They act in a wholistic fashion causing the organism to heal simultaneously at the mental, emotional and physical levels. Because they are both safe anc effective and have been proven to work in laboratory and clinical studies, interest in their use is growing.

Key Words: Homeopathy, Law of Similars, Proving, Potency.

Two hundred years ago a German physician, Samuel Hahnemann, became disgusted with the medical treatments of his time, seeing them do more harm than good. He decided to quit his practice and devote full time to medical translating. When Dr. William Cullen suggested that the mechanism of action of Chinchona bark in treating malaria was because of its bitter properties, Hahnemann decided to try it on himself. He took the bark for several days and began having sweats and other symptoms similar to malaria These symptoms subsided in about a week. A month later Hahnemann took the bark again and again the malaria-like symptoms recurred. He then formulated the hypothesis that a substance which produces a particular pattern of symptoms in a normal person will cure the same pattern of symptoms in a sick person. From medical translating he was familiar with this hypothesis from the writings of Paraceisis.

He proved this hypothesis by testing other medicinal herbs on himself and other healthy people, and then treating sick people with the similar pattern of symptoms and saw them get well. He was determined to eliminate toxicity so was using the lowest possible doses to get these results. As time went on and more substances were tested, he wrote these medicines and their particular symptoms into a book called the Materia Medica. The testing of a substance on normal healthy people he called a *proving*, which forms the basic symptom picture then used to match to sick people with similar symptoms. He called this the *Law of Similars*, or the principle that like treats like. His hypothesis was confirmed many years later in the physiology lab and you will find it in your medical dictionary as the Arndt-Shultz Law which states that small doses of drugs stimulate (the homeopathic effect), moderate doses suppress (the drug effect) and large doses kill.

Hahnemann first used herbal tinctures and in some cases a 1:10 dilution. After a few years he noticed that his medicines used for house calls acted more strongly. He reasoned that perhaps the agitation from riding in his horse drawn buggy somehow made the medicines stronger. He then tried preparing his medicines by imparting kinetic energy by shaking the medicine vigorously 20 times with each dilution. This technique was later called *succussion*. He discovered that each medicine acted more strongly with each dilution only if it was succussed. If the medicine was merely diluted it became gradually weaker until it had no effect. He then was using medicines diluted 1: 10 six to twelve times. As time went on higher dilutions were made, e.g. 1:100 any number of times.

The controversy about these homeopathic dilutions escalated when mathematicians showed that by diluting a substance 1: 100 twelve times no molecules of the original substance could remain. Perhaps because Einstein had not yet shown the correlation between energy and matter, most physicians couldn't accept that these highly

(Continued next page)

diluted medicines could do anything. No one has yet explained why imparting kinetic energy at each step of dilution keeps the medicine active. Although the mechanism of action of a homeopathic medicine is yet unknown, it somehow stimulates healing at all levels simultaneously, e.g. mental, emotional and physical levels. Therefore it is a wholistic effect. Laboratory and clinical studies have shown the effectiveness of these medicines.[1-10] It is also interesting that one of the fastest growing uses of homeopathy is in veterinary medicine (animals don't respond to a placebo effect).

Homeopathic medicines are made to rigid standards by homeopathic pharmacies supervised by the Homeopathic Pharmacopea of the United States, which is overseen by the FDA and has been in existence for over eighty years. Homeopathic medicines are made to various potencies, according to how they are diluted and how many times they are diluted. Therefore, the higher the dilution, the higher the potency.

Because each homeopathic medicine treats only a specific symptoms or "symptom picture" (akin to a syndrome), a medical diagnosis by itself doesn't lead to the correct medicine for that person. For any diagnosis there may be thirty or more possible homeopathic medicines to consider, and it is usually necessary to find the correct medicine or else little or nothing happens. This potential difficulty in finding the correct medicine can require a great deal of patience for both the patient and practitioner and is a major reason why there are so few homeopathic physicians. Even when the correct medicine is found, progress may be slow. But the advantage is that any improvement tends to become permanent. Any disease process which is capable of being healed can respond to homeopathic treatment, including many conditions which drugs can't help, e.g. chronic fatigue syndrome, etc. Although the goal of the homeopathic physician is to remove drug dependence, drugs will always be used as necessary to keep the patient safe and functional.

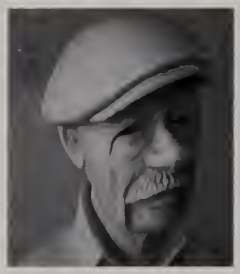
Homeopathic medicines are nontoxic. But if a medicine is overused/abused it can produce a permanent "proving", thereby causing added ongoing symptoms. In an effort to circumvent the difficulty in prescribing, certain medicines have been made using a combination of low potency homeopathic medicines. These you will find in the health food stores with labels such as "cold", "cough", "allergy", etc. The overall effectiveness of these preparations is less than that of the individually prescribed medicine.

Homeopathic medicines have no direct interactive effects with drugs. However, continued use of drugs can interfere with the healing effect of a homeopathic medicine. Homeopathic medicines cannot cause physical damage or allergic reactions. Although Europe and the rest of the world leads the United States in physician education, programs with CME credit to learn "Primary Homeopathy" are currently being started in the United States and more medical schools are now offering courses.

Although there are few "specifics" in homeopathy, there is one medicine that all physicians can easily use to their patient's benefit. *Arnica Montana* is very useful for any type of trauma or injury, including surgery and head injury/concussion. It is available at health food stores and some pharmacies. We would suggest using the 30C potency. The patient puts eight to ten pellets under the tongue and lets it dissolve. It can be repeated about every six hours to total of four to five doses as needed. For surgeries use an additional dose just before the procedure. This medicine will reduce pain, swelling and bruising. It will not interfere with any other drugs used simultaneously.

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Let Seniors Beware

by Tammy Biehler and Vincent Clarkson
Elder Abuse Prevention Program

To most people, Frank Abagvale, Jr. came across as a "nice man". He was smart, polite, attractive, well dressed, had a winning smile, spoke knowledgeably and was charming. Abagvale was also very successful at his work. In one five year period, he made over $2,500,000 — all of it tax free.

But Abagvale did have at least one rather disconcerting characteristic. He was a ruthless swindler. Like most swindlers he could easily lie, steal and act aggressively against others to the point of doing harm. The rights and emotions of others were of no concern to Abagvale. He made his money by defrauding people, many of whom were elderly, including his own father.

"Dad possessed the one trait necessary in the perfect pigeon — blind trust, and I plucked him for $3400" Abagvale confessed in his telling self-expose, ***Catch Me If You Can.***

Abagvale's defrauding of his own father underscores one of the primary "modus operandi" of con artists: They want to get their money without working hard so they look for the easiest victims to swindle — and the easiest victims seem to be the elderly.

Statistically, people over 65 years of age comprise about 13 percent of the U.S. population and yet they make up 30 percent of all fraud victims and 60 percent of the victims of health fraud.

Louis Mizell, a personal security expert, writes in ***Street Sense for Seniors*** that "thousands of the elderly have lost their life savings and tens of thousands have lost their dignity and their hope for the future. Some have even lost their lives."

One of the most outrageous cases of financial abuse against seniors reported recently in the press — and yet a rather typical case, is that of Susan and Lowell Engel. This elderly couple entrusted their life savings to their minister, the Rev. James S. Castria, by adding his name, for convenience only, to their savings account. The "good" minister proceeded to reward their trust by bilking them of $40,000 or so. When the Engels discovered the embezzlement and confronted their spiritual guide about his malfeasance, he murdered them. Five days after the Engles' bodies were found, the Rev. Castria committed suicide.

Dr. Robert N. Butler, in his Pulitzer Prize winning work, *"Why Survive? Being Old in America"*, writes, "Not all older people are victims of fraud, of course. But an important minority are highly susceptible . . . Collectively, the elderly constitute a significant source of income (to swindlers) given their $60 billion of annual aggregate income, and, with their own frailties and vulnerabilities, this makes them tempting prey."

Butler pushes on to point out that it is not age per se that makes the elderly susceptible to fraud. "People do not automatically lose their intelligence and judgment as they grow older," he says. Rather, it is a variety of factors which can and may contribute toward making older persons vulnerable: Current medical status, the presence of organic brain damage, loneliness, grief and depression, the fear of aging and death, pain and anxiety, educational level, personality, cultural characteristics and poverty — among other factors.

There will always be people like Frank Abagvale, Jr. (who's no longer in the business of swindling) who are looking for seniors to victimize. So, the question is not will most, if not all, older Americans be approached by a swindler, but rather when.

Butler says that much can be done "to protect the elderly against fraud. Consumer educational campaigns are obviously of importance. . . the communication media, television, radio, newspapers and magazines. . . could certainly help to alert and educate the elderly to the tactics of fraud. . ."

There are indeed many avenues open for seniors to learn how to protect themselves from fraud but perhaps the best way for them to avoid becoming victims of fraud is to read about their peers' experiences.

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Indicators of Abuse, Neglect, and Exploitation of the Elderly
(We recommend you clip this page and keep it for future reference)

PHYSICAL APPEARANCE

- Burns - especially unusually located
- Bilateral bruises on upper arms (from shaking)
- Clustered bruises on trunk (from repeated striking)
- Bruises resembling an object
- Old and new bruises
- Swelling of joints w/weakness or lacerations/welts/black eye, fever
- Bone fracture/signs of fracture
- Bed sores
- Unhealed sores/untreated injuries
- Tremors
- Broken glasses/frames
- Lack of prosthetic device
- Same clothing all the time
- Shoes on wrong feet
- Odorous
- Fleas/lice
- Rash/impetigo/eczema
- Hair thin (as though pulled out)
- Wheezing/persistent cough
- Unintentionally non-communicative
- Untreated medical conditions
- Intentional/unintentional over-medication by caregiver
- Severe/constant pain
- Swelling of legs or ankles
- Coldness in parts of body
- Red, painful eyes
- Coma
- Bluish feet (vascular problem)
- Vomiting
- Shortness of breath
- Chest pains
- Sudden weight loss/gain
- Blood in excretion
- Heat exhaustion
- Incontinence
- Dehydration
- Malnutrition
- Scars
- Decayed teeth
- Dilated pupils
- Narcolepsy

BEHAVIOR

- Recent/sudden changes in behavior
- Changes in will/representative/payee/P.O.A.
- Paying exorbitant prices for things
- Depleted bank account w/nothing to show
- Large amount of purchases on credit
- Frequent requests for income supplements
- Unjustified fear
- Unwarranted suspicion
- Unreasonable excuses
- Unaware of financial status
- Chronically fails to pay bills
- Unwillingness to talk
- Denial of problems

ENVIRONMENT

- Hazardous conditions
- A lot of outdated medications from different Drs.
- Lack of electricity/heat/water/etc.
- Urine/feces odor
- Soiled bedding/furniture
- Disappearance of property/household items
- House infested with bugs
- Meds not clearly marked
- Roof leaks
- Overcrowding
- House too cold/hot
- Burst water pipes
- Frequent moving
- Evidence of restraint
- Empty liquor bottles

BEHAVIOR OF FAMILY/CAREGIVER

- Marital or family discord
- Elder locked away
- Striking/shoving/name calling/etc.
- Conflicts with others in community
- Family does not interact with client
- Hostile/secretive/frustrated/shows no concern
- Manipulates elder into lending money/paying bills
- Someone other than caregiver brings elder in
- Prolonged interval between injury and treatment
- Transfer of property/savings/insurance/will
- Inconsistent explanation of injury
- Caregiver lacks knowledge of care needed
- Elder left alone for extended periods
- Does not provide needed personal care
- Overly frugal
- Does not allow visitors
- Recent family crisis
- Unrealistic expectation of elder
- Doctor hopping
- Unexplained cash flow
- Unusual household composition
- Other unreported injuries found
- Resentment by caregiver
- History of mental illness in family
- Alcohol/drug use
- Excessive payment for care
- Withholds food/medication
- Sudden appearance of previously uncaring family
- Continuous friction
- Resentment/jealousy

Follow-up - Lost/delayed insurance claims

by Edie Register and
Marilyn Rissmiller,
CMS Department of Health Care Financing

"CMS will be contacting all of the insurance companies that were identified as 'problems'."

Due to increased concern from members, CMS issued a call for testimonials on lost or delayed claims in the March 1997 edition of *Colorado Medicine*. Despite the fact that the project began slowly, the overall response to the request for information on claims processing delays has been good. The CMS Health Care Financing Department has been working on this project since March.

Once the data was compiled, it became clear that the majority of members' concerns were associated with PacifiCare (formerly FHP) and Sloans Lake. CMS staff met with representatives of both organizations to address these concerns. The meeting with PacifiCare was very successful in terms of cooperation and feedback. (Listed below are steps that can be taken to alleviate many of the problems uncovered during our meeting with PacifiCare.) In fact, we were able to set up ongoing monthly meetings to review additional problems and questions.

CMS met with representatives of Sloans Lake and were advised that although they had experienced problems last year, their processing has been current for some time. This is a positive note, and something CMS will monitor closely via member complaints. They informed us that they do not have access to claims processing information in their office and that CMS would have to contact the insurers directly. CMS has begun this process and awaits responses from the insurers.

Please continue to send us your information on claims processing delays. CMS will be contacting all of the insurance companies that were identified as "problems" by members. As we work through this process, we will be providing the individual offices that provided the claims information feedback

Findings from meeting with PacifiCare

In reviewing our members' claims with the PacifiCare claims processing personnel, CMS identified a number of areas that routinely cause problems for the doctor's office or PacifiCare. The following are suggestions/reminders to avoid:

- **Question on the status of a claim**: If a claim has not shown up on a voucher as pending or processed after 30 days from when you submitted it go ahead and rebill. However, it is important for bookkeepers to not only reconcile the PacifiCare payments, but also note in the billing records any denied and pending claims including the date of the voucher. (This will save time later if it becomes necessary to "prove" timeliness.)
- **Membership information**: PacifiCare will try to verify the membership information given by matching name, number and/or birth date, if they cannot the claim will be returned to the doctor's office. If the patient's coverage was terminated prior to the date of service or if they have no membership record for the patient, the claim will be returned to the doctor's office. In these instances, there is no record of the claims in their system and they have "no record" of receiving

them. For this reason it is important to have current/accurate information, one way of doing this is by making a copy of the insurance card and verifying that there have been no changes since the last visit.

- **Referral information**: If the referral number is not submitted on the claim, PacifiCare's internal procedures are to pend the claim, and manually look up the referral. If one is found, the claims processor will enter it on the claim. This manual intervention can add as much as 30 days to the processing time. By entering the referral number in box 23 of the HCFA 1500 form you can speed up the processing of your claim.
- **Prior Authorization**: If the service being billed requires prior authorization, that number should be entered in box 23 of the HCFA 1500 form. If it is not, the claim will pend for a claims processor to look it up and payment will be delayed. **Note**: Box 23 can only hold one number but it is to be used for either the referral or prior authorization number. If you are billing for two services, one that requires the referral number and one that requires a prior authorization number, you should bill them on two separate claims forms to avoid keying errors and delays.
- **Data Entry**: The majority of PacifiCare's data entry functions have been contracted to an outside company. These data entry operators do not have access to PacifiCare's computer system and do not understand all of the intricacies of the claims information. They will enter the information exactly as it is submitted. Therefore it is important to be sure your claims are clear and that information is in the appropriate box.

Unfortunately, for certain specialties, some of the billings will take longer to process as they may need to be manually reviewed for multiple surgery pricing or a determination on cosmetic surgery. However, following the above suggestions may be of assistance by eliminating those additional delays that are within your control.

CMS staff will continue to meet with PacifiCare to review any new problems, and keep the communications open. We feel that PacifiCare has made improvements, but we want them to know that we intend to stay involved on behalf of our members. If you have any questions or if you have additional documentation, please let us know.

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CopicComment

Jerome M. Buckley, M.D.
Chairman & CEO
Copic Insurance Company



"Long-Term Care Insurance, Part 2: Picturing the Solution"

In the previous Copic Comment, I outlined the medical, financial and demographic issues that create the need for long-term care insurance: our elderly population is growing and the government cannot pay for all of the care and treatment they require.

Pointing out the problem is always easier than providing the solution, but as Colorado physicians, we have a duty to consider the consequences of not getting involved. As a profession we have largely conceded the debate on traditional healthcare financing to out-of-state, non-medical interests. The result is that we must now negotiate on our patients' behalf with insurers and HMOs whose financial objectives generally drive them to restrict access to care. This influence on our profession by commercial interests is a danger that we struggle with on a daily basis and one that in hindsight might have been avoided if we had acted decisively at the right time.

Looking at that painful experience, we must now decide on our response to the challenge of long-term care financing. The choices are essentially simple. We can either get involved and provide our solution or let the same Wall Street players who gave us for-profit HMOs give us their unique brand of care when we are old and gray.

Our own self-interest is aligned with that of the community as a whole because we, too, will need long-term care when we get old. Our parents and spouses will also need long-term care, and we want to have the highest quality services and insurance to provide that care.

Anyone who has been through the experience of caring for an elderly relative knows how difficult it is to find the right care setting and the right provider, and then arrange for the payment.

At Copic, we believe that the long-term care solution must incorporate the following characteristics:

- Financial integrity
- Flexible care options
- Quality-driven vs. profit-driven
- Local control

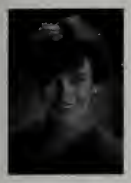
We all understand that financial integrity is what allows us choices and options for the future. This is particularly true for long-term care, because what works today will not always work tomorrow. Traditional nursing homes will give way to more home care and assisted living facilities. The goal of insurance should be flexibility... not to reimburse a specific or narrow type of care, but to give independence to patients in deciding what care is best for them.

Quality versus profit is an old debate that doesn't need to be raked over here, but it is fair to say that no healthcare plan ever got better by giving commercial investors a huge profit off the top. There's a place for profitable investment in healthcare, but as a community we have learned that there are perils involved in sending money outside the system. Those who provide outside resources naturally look for a return. By contrast, the more we do for ourselves (assisted living, etc.), the more resources there are to devote to quality of care.

The last issue is local control. This is not a parochial interest but a way of supporting the very goals of independence and quality of care. As healthcare financing has changed over recent years, we have seen money flow out of Colorado to corporations on both coasts. The decisions these corporations make are based on their profit targets, not on what is best for Colorado healthcare. A controlling local interest is a guarantee of quality to us and our families that no outside interest can make.

Physicians have sometimes lacked the cohesiveness which would allow us to act decisively on healthcare financing. Long-term care is our opportunity to show that on issues of quality, we can be the guarantors and not merely the gatekeepers. In next month's issue, I'll describe in detail Copic's plans to assist each of our policyholders in seizing that opportunity.

Colorado Medical Society Alliance



Stella Shanks,
CMSA President

75 years old and still needed

Our Alliance celebrates its' 75th year this September. As we end a very successful year and begin a new one, it is well to reflect on where we have been in order to get a good idea of where we need to go. As AMAA President, Johnnie Amonette said, "We are an organization in transition . . . ..we are not the same people we once were." Rose Pollard, who compiled our 75 years of history has a real sense of who we once were and who we now are. Rose says, "We can proudly point to the innumerable hours of accomplishments in community service on behalf of public health, medical education and legislation that have been contributed by hundreds of willing minds and hands. This could only be achieved by a great deal of effort and cooperation."

In the past year, I witnessed this effort and cooperation as well as dedication, commitment and a willingness to change. I visited eight counties this year, some more than once, and found members who were very willing to lead and take on a large share of the organizing of activities. They tailored their programs to the needs of members and it has strengthened our Alliance. These members know the value of the Alliance and its' importance in our communities.

The past year also saw CMSA board members hard at work. Our board meetings were always well attended and much was accomplished. A good turn out at the Day at the Capitol emphasized to legislators, that CMSA is a grass roots organization whose members want to affect change and are willing to give their time to bring about these changes. The annual meeting, in Vail had the smallest attendance in history....four! Due to a raging snow storm, all members to the east of Vail were prevented from attending. Our disappointment was compounded by the fact that our invited guest, Johnnie Amonette also could not attend. We were fortunate in that our facilitator, Carolyn Foxe of Visalia, from California, had flown in the day before and so ideas, suggestions, concerns and solutions flowed over two days and it was declared a successful meeting.

We had double that attendance at our May meeting, also in Vail and again more ideas, suggestions and solutions came forward. Our officers were installed at this meeting, we introduced Donna Foss, our new part-time secretary and Dr. Gary VanderArk spoke to us, urging all members to be involved at the CMS Annual Meeting in September. We may be in transition but thanks to a dedicated core, we are alive and well.

I was very proud to represent CMSA at the AMAA Annual meeting of the House of Delegates this June. Our state can be proud of its' accomplishments and take pride in its' members. We are also well represented at the national level. Patti Brown (past- president CMSA) serves on the Legislative Committee. Mary Hanson was one of 20 national past- presidents in attendance. And I was elected to the Nominating Committee. We will certainly keep Colorado in the forefront and continue to have input on what affects you, our members. Our two delegates were Leslie Nathan and Sue Foerester, from El Paso county. I am very pleased to announce that they are our nominated President-elects.

What was uppermost in the minds of members in 1939-40 is still true today -- the building of friendships among physicians and their families throughout the state. Let us continue that great tradition and be proud that we are 75 years old, still needed and still contributing to our society.

The goals of CMSA for 1997-98 are:

- All members be full members of AMAA -- we are made up of three parts, but are just one organization. We cannot succeed without the whole family working together. Leaders at all levels know that we cannot exist without each other. This is a necessity not a choice! So please join the AMAA. CMSA and your county this year, with your time your talents and your dues. (Dues in 1992 were $1 per year, $.25 went to National).
- Continue to **S**top **A**merica's **V**iolence **E**verywhere – particularly in the areas of domestic abuse, elder abuse and media violence. Also continue the Save-A- Shelter campaign.
- Be part of the Legislative team – we can all do our bit to bring about change. Your medical society will be asking you to help them with a mini-intern program this fall, please help.
- Continue to support "your doctor of tomorrow" and medical research by donating to AMA-ERF. In the past 20 years, we have given CU Medical School $637,688 and another $100,000 has been given to other schools by Colorado physicians.

Some thoughts on the CAC's and the LMRP's

by Grant Steffen, M.D.
Medicare Medical Director for Colorado

Do you know who your representative is on Colorado's Carrier Advisory Committee (CAC) is? Do you know what the CAC is? Do you know what it does? If you answered no to any of these questions, read on.

The CAC is a committee of physicians that meet quarterly to advise the carrier (Medicare Part B, Blue Cross Blue Shield of North Dakota) on proposed local medical review policies. Dr. Louis Sullivan, Secretary of HHS under President Bush, mandated, in 1992, that each state have a committee made up of representatives from all of the major specialties in medicine as well as representatives from the podiatric, chiropractic, osteopathic, and optometric communities. The committee's task is to advise the carrier on the contents of local medical review policies (LMRP), those policies developed when there is no national policy.

The CAC in Colorado has been meeting quarterly since November, 1992. Besides advising the carrier on LMRP's, it has taken on other tasks. When Medicare presents a new national policy to the physicians, this carrier has no discretionary powers to change it. However, the CAC can be a channel through which the CAC members and their constituents can voice their agreement or disagreement with the proposed national policy.

The CAC is not the proper forum to discuss personal problems with the carrier (denials, reviews, and the like). However, if a physician has a personal issue that has general relevance, then the CAC may discuss this general issue.

The LMRP's may begin as model policies developed by Carrier Medical Directors (CMD's) like myself, and offered to all carriers for their implementation. HCFA hopes that by the carriers adopting these model policies, coverage and payment issues will be handled uniformly across the country. As you know, one of the big complaints about Medicare is that one state will allow a procedure and the next state will deny it. The model policy program will, I hope, decrease this variation.

This carrier also "borrows" policies from other carriers when these policies are thought to be useful when we do our medical reviews, and when we have not already addressed the issue. Finally, we may write our own LMRP when we discover a widespread abuse or misunderstanding concerning billing Medicare covered or noncovered services, or when a new procedure has been approved by HCFA and diagnostic guidelines are needed.

These LMRP's are submitted to the CAC for its discussion and recommendations. This carrier depends heavily on the CAC for its advice since the experience and knowledge that the members bring to the table are unmatched by any other forum available to the carrier. The members are asked not only to give their input to the CAC but also send the policies to their constituents and to bring to the CAC those concerns raised by them.

When I send the proposed LMRP's to the members, a 45-day comment period begins. This mailing goes out two to three weeks before the meeting. Since I also chair the CAC's in North Dakota, South Dakota, and Wyoming, the 45-day period does not end until the last CAC has met and its 45-day period expires. Following this process of discussion and advice, the LMRP is published in the Medicare B News Bulletin and takes effect usually 30 days later.

The state chapters of the national specialty societies have the task of appointing members to the CAC. If there is no state chapter, I have contacted the national society directly for its recommendations. If you are curious to know who your representative is, call me at (303) 858-5633.

CMS is represented on the CAC by Ray Painter, M.D. Dr. Painter is also currently serving as Co-chair of the committee. Staff from the CMS Health Care Financing Department attends the CAC meetings and monitors the issues being discussed.

As Dr. Steffen indicated, the CAC serves an important role as a "voice" for local physicians. The specialty societies (generally local) select their representatives and rely on them not only to solicit input from their constituents, but also to provide feedback.

Dr. Steffen mentioned the model policies, because of the desire for national uniformity these seem to be on the increase. CMS staff has heard that there is a desire to have the national specialty societies involved in the development process of the model policies. This certainly would strengthen the physicians' input.

-Marilyn Rissmiller
CMS Dept. of Health Care Financing

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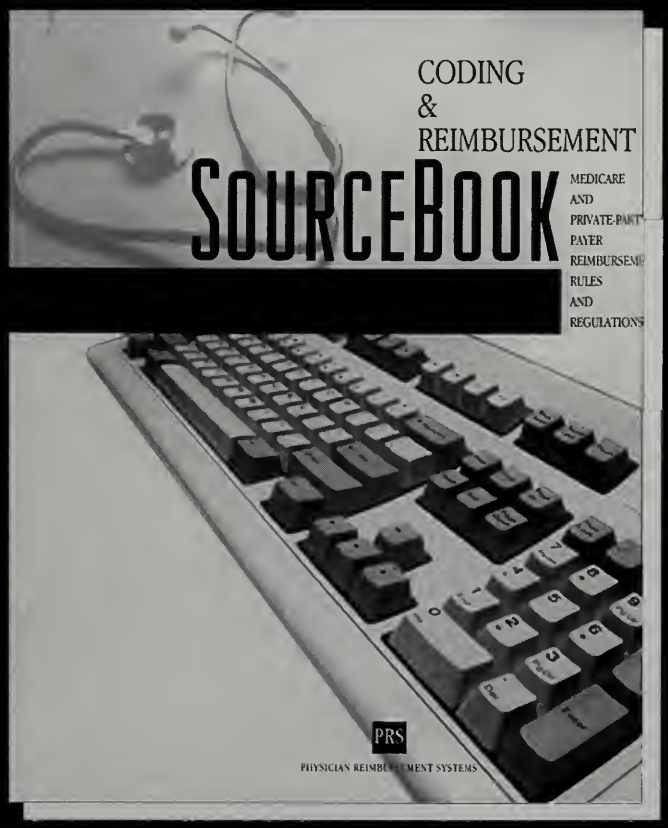
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by David P. Halsch
Senior Financial Consultant

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- identify your financial needs
- avoid overlooking important areas of concern; and
- prioritize goals for your practice.

A Comprehensive financial plan should:

- Provide an overview of your financial situation. It should set the stage and answer the question, "Where are you now?"
- Focus your attention on the achievement of future goals. It should help you answer the question, "Where do I want to be?"
- Help you and your advisor set priorities and establish strategies for achieving specific financial goals. In other words, "How can you get there?"

Because your practice's financial health can be substantially affected by your business environment, some plan preparers present information that helps you understand the outlook for your medical specialty. This may include analyses of growth rates, business potential, factors affecting growth in your industry and region, and relevant recent or pending legislation.

Once your plan is complete, you will need to put it into action. Many financial advisors offer support throughout this process and call in any specialists you will need. For example, a financing specialist may be called upon to help structure a loan transaction, or a succession planning specialist might be contacted to assist in the sale or transfer of your practice.

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John L. Lightburn, MD
Historian
Colorado Medical Society

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"In the breaking up of customs and traditions, in the revision that war has brought in our habits of life and schemes of education, great opportunities open up before the medical profession to turn the thinking of all democracies to ideals of better health and healthy living. Let us be active with thoughts and voice and pen to take up the leadership that rightly belongs to us in this new time."

Edward Jackson M. D.
in his presidential address
to the House of Delegates
Colorado Medical Society
September 11, 1918

In Snowmass Village next month, genial neurosurgeon Gary D. VanderArk will take over the reigns of the presidency of Colorado Medical Society (CMS) from M. Ray Painter, Jr., the well known urologist from Denver. The meeting theme will be ***"Orchestrating Community Health",*** and Dr. VanderArk's challenge will be to bring harmony to a medical community that recently has produced some sour notes in disparate efforts to deal with the challenge of managed care. Looking back, we find that there were some sour notes eighty years ago when Alexander C. Magruder, an ophthalmologist from Colorado Springs and 47th president of CMS, also faced a challenge as he assured leadership of a medical community facing a crisis of a different sort. A year later, with the country still in crisis, Edward Jackson spoke words that Dr. VanderArk might say next month. Let us see how our society and our profession faced World War I.

On April 6, 1917 the United States entered the Great War in Europe which had come to a stalemate after three horrendous years of fighting. At the time war was declared, there were only 200,000 men in the U. S. Army and by June 17 the first units of the American Expeditionary Force landed in France. Thousands of men were drafted and by the time the war ended , there were five million men in the Army. To provide for the medical requirements of such a large force, many thousands of physicians were needed. They were asked to leave their practices and volunteer in the Medical Reserve Corps. Some Colorado physicians volunteered immediately. Indeed, some had been concerned about the tragic situation among civilians in Europe and had gone overseas before the U.S. had entered the war. For example, Dr. W. A. Jolley, of Boulder, went over as a volunteer with the American Red Cross and served in a hospital in Serbia.

The War Department wanted 20,000 physicians and Colorado was asked to send 245.

One of the early volunteers was Alex Magruder. He had been a successful ophthalmologist in Colorado Springs and at age 51, closed his office and went to war, beginning his military training at Fort Riley, Kansas. He was president-elect of the CMS and obtained leave to return to Colorado Springs for the annual meeting. It was September 27, 1917, and for six months the army had been begging Colorado physicians to volunteer and accept commissions in the military. Of Colorado's quota of 245, only 143 had responded by that date, and of these most were in there 50s, some were 60 and one was 71. So in his presidential address, Alex Magruder gave his colleagues a thirty minute tongue lashing. He was eloquent and filled with patriotic fervor as he began his address: "This, ladies and gentlemen, is probably the most momentous meeting that the Colorado State Medical Society has ever had; save, perhaps that first meeting forty-seven years ago..... That first meeting witnessed a union of the medical profession of Colorado for closer social and scientific association. This meeting... marks a separa-

tion; for when we look about us we miss many familiar faces of those who have already answered the call. This meeting marks a time in the history of our society, and in the lives of many of us, which may mean defeat and failure as individuals and as a nation or success as individuals and glory as a nation... What we must bring ourselves to see and know, and that quickly, is that the environment has changed and that our duty is to throw ourselves, heart and soul, into the new order of life". He continued for thirty minutes trying to motivate the young physicians to volunteer.

Then he said, "Under provisions of most of our constituent County societies 25-50 percent of the money collected by the doctor staying at home from the patients of those going to war is turned over to the families of those serving". Not satisfied with this, he went on, "I strongly recommend an assessment ranging from $5.00 to $25.00 a month be assessed every member of this society for distribution to the Roll of Men" to make up for the meager pay in the service. The House of Delegates did not respond positively to this recommendation.

Not content with his own eloquence, the next day, there was a Patriotic Rally in connection with the meeting where equally fervent but less eloquent and less lengthy speeches were given by Governor Julies C. Gunter, Captain Francis Treeses of the 20th French Field Artillery and Dr. James A. B. Scherer, member of the council on national defense, Washington. D. C. These speeches were apparently effective, because within a few months, Colorado's quota was met. When not occupied with the task of motivating young men to do their patriotic duty, Alex Magruder was not a critical or unkind man. He was a genteel and courteous man from a "very old family" of the deep south.

The University of Colorado School of Medicine under Dr. John Amesse organized a military hospital with twenty-two doctors. They set sail on July 4, 1918 and established Base Hospital #29 at Tottenham, England.

By the end of the war, one-sixth of Colorado's physicians were in the armed forces. In the summer of 1918, ***Colorado Medicine*** reported that there were over 10,000 physicians in training at Fort Riley, Kansas. When the Armistice was signed, there were 5,000,000 men in the Army, 2,000,000 of whom were in Europe. The fighting was fierce and the cost was tremendous. There were 230,000 Americans wounded and 112,000 deaths, many from influenza (more about the influenza epidemic later).



Officers of Base Hospital #29 at Tottenham, England. This contingent of volunteers was from Denver, Colorado. We do not have the identities of the individuals in the photo (circa 1918)

While the boys were fighting and dying in Europe (yes we called them boys back then), what was happening on the home front? Physicians served on Medical Advisory Boards which were responsible for screening the men called up in the draft. These boards usually were composed of a surgeon, an internist, radiologist, eye, ear, nose and throat specialist and urologist. With the draft, almost all the state's young men received medical examinations. There were a large number of medical rejections. The nation was surprised and shocked by the large number of young men who were physically unfit. Especially troubling were the number of cases of venereal disease and tuberculosis that had been discovered. ***Colorado Medicine*** reported "startling prevalence of venereal infection among enlisted men has stirred the government to unprecedented action ..." The United States Public Health Service and the Council of National Defense had sent to all the state boards of health proposals for the prevention and control of the disease. Among the proposals were the establishment of state bureaus of venereal disease, venereal disease clinics, massive education campaigns and suppression of prostitution. These events moved the city fathers of Denver to pass an ordinance making venereal disease reportable. In a speech to the Rocky Mountain Public Health Association, C. G. Hickey, M. D., described the statewide program for venereal disease. This comprehensive effort to deal with a disease that had recently been unmentionable brought a mixed response from the medical community where concern for the confidential nature of the physician/patient relationship was paramount. It took another thirty years and the introduction of penicillin before we achieved effective control of those dread diseases.

In response to the increasing shortage of physicians the Medical Women's War Service League was established by women physicians nationwide. They tried in vain to persuade the army to accept women into the service. The focal group was led by M. Ether V. Fraser with assistance from Madeleine Marquette Baker, Mary E. Ford and others. They developed their own training program and gathered and shipped over a thousand pounds of clothing for the children of Europe. Frustrated in her efforts to enlist in the Army, Dr. Fraser finally went to France on her own and joined other American women physicians to establish a military hospital under the auspices of the French Army.

As the war wore on and fatalities

(Continued on following page)



Ward 1, 29th Base Hospital, Tottenham, England

multiplied, the initial patriotic enthusiasm was slowly replaced with pain, anger and intolerance. Good Americans with German ancestry were shunned, isolated and sometimes harassed and even persecuted. Physicians were no exception, and I remember Dr. Herman Maul telling of his travail during those hard times. The Army continued to enlist more physicians and the shortage of physicians became more severe. In Washington, there was talk of drafting all physicians under the age of 50 and assigning them to communities where the shortage of physicians was severe. To avoid this troubling development, The Volunteer Medical Service Corps was established to supplement the Medical Reserve Corps to provide medical expertise where it was most needed, such as epidemics or serious shortages.



Surgical team, 29th Base Hospital

When the Colorado Medical Society held its annual meeting in September of 1918 at Estes Park, much of the meeting was devoted to the war and its consequences. Letters from former officers of the society now in the service were read at the opening meeting, and President Edward Jackson devoted much of his presidential address to the need for continued support of the war effort, the need for a continued effort to control venereal disease and the need for more volunteers to the new Volunteer Medical Service Corps. Sixty days after he presented his address at that meeting, the Armistice was signed and the fighting stopped.

In the same issue of ***Colorado Medicine*** that contained Dr. Jackson's address, an ominous announcement was printed with a prominent black border:

A new medical crisis was about to confront us.

Editor's Note:

The photographs are from a group of photos supplied ***Colorado Medicine*** *by Charles H. Quewary, Jr., MD, of Denver. Dr. Queary said his father, an enlisted man who probably worked in the clinical laboratory. Tottenham, England, is a suburb of London. None of the personnel in the photos was identified; however, Drs. John Amesse and Robert Packard were known to be among the 29th Base Hospital volunteers.*

BULLETIN ON SPANISH INFLUENZA

The Surgeon General of the U.S. Public Health Service has just issued a publication dealing with Spanish Influenza, which contains all known available information regarding this disease. Simple methods relative to its prevention, manner of spread and care of patients are also given. Readers may obtain copies of this pamphlet free of charge by writing to the Surgeon General, U. S. Public Health Service, Washington, D. C.

=0=

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COMPAC

Ilana Kutinsky, MD, honored for community service

Ilana Kutinsky, MD, a resident in internal medicine at Saint Joseph's Hospital, was honored by the American Medical Association (AMA) during its Resident Physician Section Annual Meeting in Chicago.



Dr. Kutinsky was one of 40 resident physicians from around the U.S. who was honored as part of the AMA/Glaxo Wellcome Leadership Program.

Dr. Kutinsky served as a basketball coach for the Special Olympics and as an AIDS counselor and educator for Students Teaching AIDS to Students. She developed a program on health and human sexuality of teens, which was designed to build self-respect and provide the knowledge youths need to care for themselves in a hostile inner-city environment.

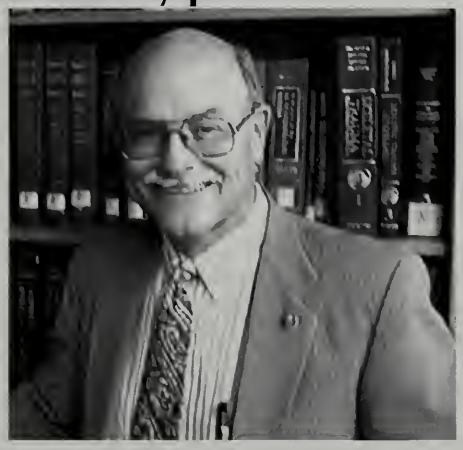
Officers assume Orthopaedic Society posts



Mark Mills, MD (L), of Lakewood, and Ben Magsamen, MD, of Fort Collins

The Annual Meeting of the Colorado Orthopaedic Society witnessed the gavel being passed from outgoing President Dr. Mark Mills, an orthopedic surgeon of Lakewood, to Dr. Ben Magsamen of Fort Collins.

Dr. Mills spent much of his time in office ramrodding legislative efforts. Dr. Magsamen, in taking office, said the comingyear doens't look much different, that there will probably be just as many high medical impact issues before the Colorado General Assembly in 1998 as there were in 1997.



Harold Yocum, MD

At that same COS meeting, Dr. Harold Yocum of Denver was rearffirmed as the Colorado representative to the Board of Councilors of the American Academy of Orthopaedic Surgeons. Dr.Yocum said much of the effort at the national level this past year has been directed at Medicare reform. Dr. Yocum, a hand surgeon in Denver, is also a member of the Colorado Medical Society Board of Directors.

Free consulting referrals for physician practices

AMA Solutions, Inc., a subsidiary of the American Medical Association, is offering AMA ConsultingLink. , a national referral network designed to help doctors find certified consultants in a variety of disciplines. The program offers consulting services to AMA members and non-member physicians in nine different areas: business planning, marketing, human resources, finance and accounting, information technology, managed care, quality assurance, actuarial analysis and general practice management.

AMA Solutions, Inc. conducts a stringent review process to determine the credentials of the consultants included in AMA ConsultingLink. The consultants are required to have experience working in the health care field and demonstrate an understanding of the industry's issues. They must complete a thorough application process, provide physician references, and undergo a personal interview.

AMA Solutions offers its services through two programs: AMA PracticeLink, which offers the AMA ConsultingLink service along with other programs targeting the needs of medical practices, and AMA PersonaLink, which offers a variety of personal services to doctors.

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RUMINATIONS

(**def:** chewing again what has been chewed slightly and swallowed; to **REFLECT**)

*by **Bill Pierson**, Managing Editor*

"I like hardware stores more than any other type of store...."



I've said it before and I'll say it again: I don't like false prophets any more than I like people wishing me a good whatever when they don't really give a damn what happens to me. In fact, most of those people hope (secretly) they never see me again.

Why is it that waiters, waitresses and cashiers can think of nothing to say, when presenting you with the check, other than "How was everything"? When I tell them that 'everything' was far short of what I had expected and hoped for, they look at me with a blank stare and don't know what to say. To help them along, I hasten to add, 'Tell your manager that, too, please'. At least, when traveling abroad (like in New Jersey or France) you can't understand the language if they do use the same closing line on you.

Another thing that troubles me immensely is that I have found few people (maybe one or two) who seemed willing to try to do anything about my discomfiture. Why did they ask?

The next closing salutation I abhor is "Thank you. Have a nice day (accompanied by a big, (precast) smile". Now really! Don't give me the kind of (non) service you have rendered for the cheesy product I have either ingested or resigned myself to buy and then have the gall to tell me how I should spend the rest of my day. If there is a grain of truth to your wishes, then why not at least put it in the proper syntax? Don't insult my intelligence by ordering me about.

If clerks and the like could be more truthful about everything, I think we all could go through our days with less stress. For instance, you walk into one of our monolithic stores and you are (quite by chance) accosted by a young "clerk" who says "Can I help you". Being truthful, I have to reply "No". If you waste your time and breath verbalizing why you came into the store, 9 times out of 9.5 the "clerk" will say something like "Gee, I'm sorry, I've never heard of anything like that," or "I don't know, but why don't you go over on Aisle 6 and ask that clerk?" I simply don't waste my breath telling them any more; I truthfully state my feelings: "No!" Why do stores hire these people and expect them to be a customer-satisfier with no training and no common sense? It just doesn't work. Just leave the clerk at the cash register, wherever that may be hidden, and let me roam; I'll figure out what I want and where it is much more effectively than if you tag me with one of these people who is more hopelessly lost than I.

I like hardware stores more than any other type of store because the clerks are usually people who either have some training in hardware, or have practical experience from using the tools and products they sell. Hardware stores generally like to hire older people to clerk because they have had more living experience. Experience is still the best teacher (at least in hardware). If you like to help people, work in a hardware store. It's an excellent place to find multitudinous lost sheep.

If someone tells me "Have a nice day!" I simply have to tell them the truth: "I have other plans".

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1997 Volume

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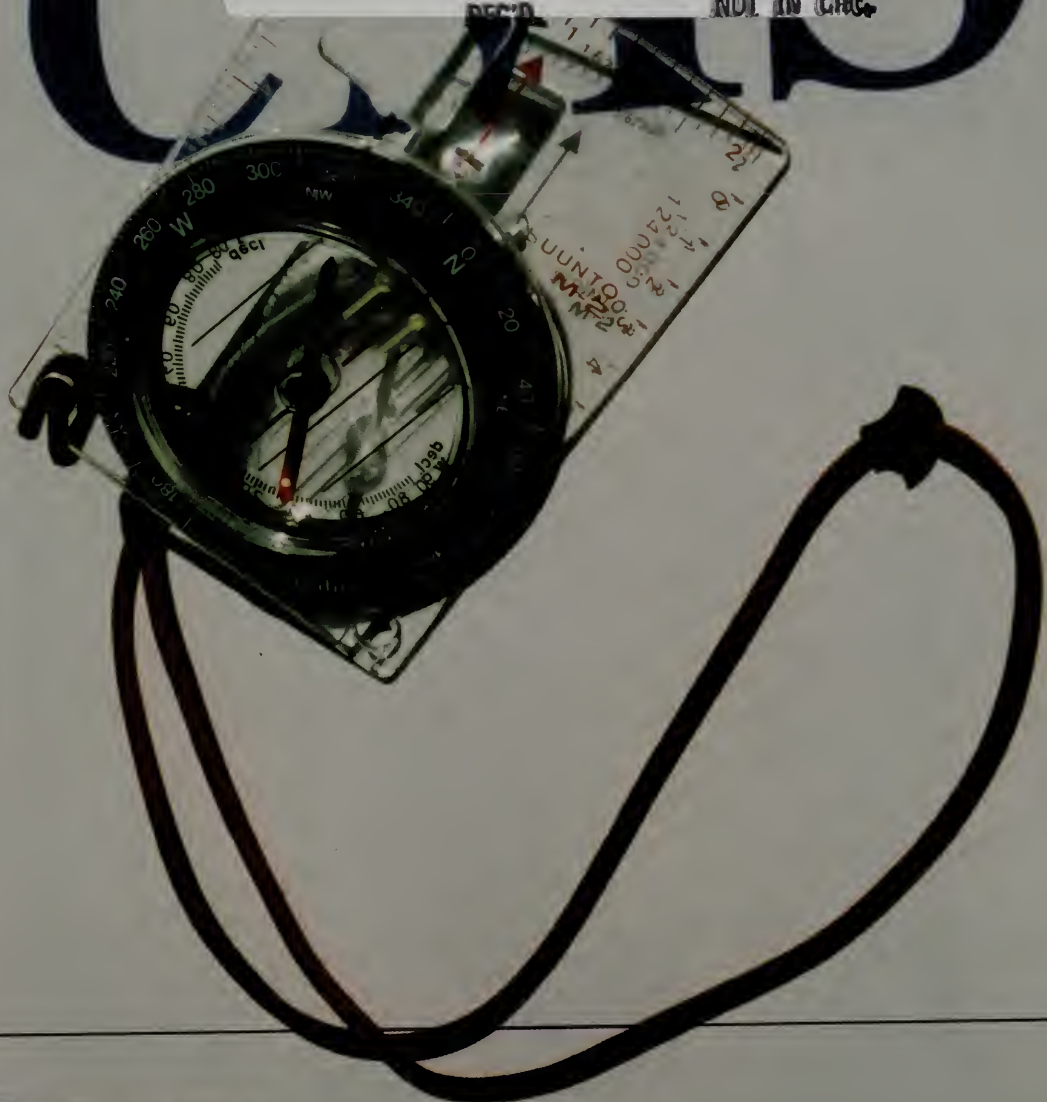
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M. Ray Painter, MD
President, 1996-1997

Road Map to the Future

Thank you for the opportunity to serve as your president this past year. It has been an educational experience. I would encourage each of you to sit in the "cat bird's seat" at some time in the future.

CMS is a well-run organization. Sandi Maloney and her staff do a superb job from year to year, both in support of the president, and in keeping CMS true to its goals. If we anticipate the status quo and are satisfied with its current function, CMS will continue to be a successful organization, with no changes required, well into the next century.

However, what if:

1) COPIC drops its CMS membership discount or loses significant market share?
2) More physicians become employees of bigger organizations and the CMS membership payment has to come from after-tax dollars?

If either of the above occurred, would CMS lose consequential membership?

Roadblocks

Change is difficult, particularly in an organization with a large full-time staff, and a voluntary board that spends a limited amount of time in pursuit of CMS business. Should we continue with our current successful and comfortable function and structure? Or, should we be willing to rethink organized medicine, particularly the function of CMS, by critically questioning how we spend time and money?

Before we can determine what CMS should do next, we must first take a hard look at what physicians need to improve their role in the system. Physicians cannot concentrate on being effective patient advocates if they are concerned about potential criminal accusations or their own economic welfare.

What do physicians need? How can physicians and patients regain control of the delivery and quality of health care? These are a few of the more commonly recurring questions I have heard as I've traveled around this year. How would you answer these questions? What action should physicians take?

In the driver's seat

Upon entering office, my personal bias was to direct CMS in creating a separate, for-profit, physicians' service organization to assist us in managing the "business of medicine". The "business of medicine" has become so complicated that it's very difficult for a physician or a small group of physicians to run their practices efficiently. "In my other life," I have evaluated coding and billing activities in many physicians' offices. From experience I can share with you that most doctors are losing 10-20% of the bottom line yearly by not adhering to good coding principles and by not understanding the rules of each payer by which physicians are paid. The flip side of that situation, as I've discussed in a previous article, is that many of us are guilty of fraudulent billing -- not by over-billing for work performed but by under-documenting the work provided or misusing modifiers, etc. We need help! However, I was surprised by the lack of support and my inability to explain this defi-

(Continued next page)

"Physicians are going to have to integrate and combine functions and services in order to develop the expertise to provide the business support that every practice needs."

ciency in a fashion to provoke action. Our task forces and our surveys indicated that most physicians are relying on other organizations to provide this function or do not understand the need.

Physicians are going to have to integrate and combine functions and services in order to develop the expertise to provide the business expertise that every practice needs.

Drawing a better map

Should CMS provide managed care contract review and negotiations, or be more involved in educating physicians as to prudent contracting? Example: A suggested alternative to the new proposed Medicare rules would pay providers the lesser of Medicare allowables, physician charges, or the *lowest of any managed care contract fee which that physician has agreed to accept.* In other words, a physician who has signed a contract for a managed care company to accept 70% of Medicare would be paid that same amount by Medicare.

Should CMS educate and give informational support to those physicians who plan to integrate? Should we collect, collate and distribute information, educating the membership to manage the explosion in information technology? I think that you know that my feeling is, "Yes." We should be active in all of the above-referenced areas. But, what do you think? Using CMS as a catalyst to solve our current health care problems could be the consummate use of its organizational potential. A good example can be found in your new president, Dr. Gary VanderArk. He is doing a superb job of orchestrating a methodology to provide care to the medically indigent.

We have a long-range planning committee (in fact we have two, working in tandem) to explore such issues. The committees plan to reassess CMS function from the "ground floor up". We're reviewing not only what we're currently doing, we are also attempting to identify the things we're not doing. Dr. Barbara Reed is chair of that committee. We need your input. This committee will have an ongoing role, initially by presenting a report on recommended functions/services of CMS at the Interim Meeting.

Final destinations

Physicians need to continue to develop physician organizations that will enable them to deliver quality, cost efficient care. Partnering with our patients to resolve coverage and demand issues will affect a team for success. Ethically managing at-risk contracts with patient groups, HMOs, employers, etc. will be a challenge, as will creating physician and other provider incentives to accomplish treatment and systems goals. Centralizing the flow of information and business function will play a role in making our system efficient and economically sound.

Historically this may be the most difficult time to practice medicine (the same could be said for the near future). Payers have the upper hand in establishing contract and payment rules. Many physicians are still more concerned about competition with colleagues and intra-specialty squabbles than with the need to organize and work collectively. All in all, physicians need a lot of assistance! Should this help come from CMS, another organization, or purely from the marketplace?

Through the "hard knocks of experience," improved information systems, patient's demands for choice and quality, and the assistance of CMS, physicians will master the free market system and regain the practice control. The future is bright!

"CMS will continue to assist physicians in mapping the proper course."

See ***"Pointing the way"*** on page 330 of this issue, a review of the 1996-1997 CMS program year during Dr. Painter's presidency.

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CMS Med Fax®

...a compilation of medically-related news briefs of immediate interest to the physician community occurring after ***COLORADO MEDICINE*** has gone to press. ***AT PRESS TIME...***

CMS Med Fax®
by Montgomery Little and McGrew, P.C.
legal counsel to the Colorado Medical Society

CCMD proposes adult and neonatal end-of-life guidelines

The Colorado Collective for Medical Decisions (CCMD) has developed guidelines for adult and neonatal end-of-life care. Colorado physicians are encouraged to review and respond to these proposed guidelines. The guidelines will be distributed to phsycians throughout the state during hospital staff meetings.

CCMD is a non-profit organization working with health care professionals and community members to develop community-based guidelines that encourage better decision-making and improve end-of-life care.

The guidelines are the result of several years of effort by working groups of clinicians, allied health providers and community members. The guidelines are still in draft form. They are intended to provide helpful frames of reference for patients and health care providers. They are not intended to replace physicians' clinical judgement and discretion, nor are they intended to detract from the fundamental importance of the doctor-patient relationship.

The adult guidelines seek to find a balance between the use of advanced, modern medicine and the provision of humane, palliative care for acute and chronic conditions. Issues addressed include: appropriate end-of-life care, comfort care, shared decision-making, CPR, permanent vegetative states, end-stage dementia, tube feeding and dialysis.

The neonatal guidelines address the limitations of medical treatments and seek to increase awareness that the dying process in some infants may only be extended with painful and prolonged interventions. Issues examined include: low birth weight/early gestational age, lethal birth conditions, comfort care and follow-up support for families whose infants are discharged from the NICU.

Surveys are incorporated into both sets of guidelines. Physician feedback is welcome. Please contact CCMD at (303) 832-3002 to obtain a copy of the guidelines

Medical Malpractice Court Case Awards Double Between 1985-95

According to a new study of the Physician Insurers Association of America (PIAA), the average indemnity payment made in 1995 was $398,426, compared to an average of $211,711 in 1985 (calculated in 1995 dollars). That's almost a 100% increase.

The information, from PIAA's database known as the Data Sharing Project, contains details on actions filed against a physician population representing approximately one quarter of those practicing in the United States.

The data reported between 1985 and 1995 revealed that:

- In 1985, the average cost of defending a malpractice

(Continued on page 3)

BME responds to physicians' use of alcohol and other mind altering drugs while on-call

The Colorado Medical Board of Examiners (BME) has been asked to respond to a question regarding the acceptability of physicians' use of alcohol or other mind-altering substances while on-call for medical practices, clinics, hospitals or other treatment settings.

In response, the Medical Board advises against using any mind-altering medication not prescribed by the physician's treating doctors, and advises against the use of alcohol by physicians when on-call. Although the use of these substances while on-call is not specifically defined in Section 12-36-117, C.R.S., as a viola-

(Continued on page 3)



Med Fax: Medico-Legal News

by Karen B. Best, Esq., an associate with the law firm of Montgomery Little & McGrew, P.C.

This column contains information concerning topics of general interest in the medical-legal field. For further information or help with specific problems, please contact Montgomery Little & McGrew, P.C.

Colorado BME: Disciplinary Actions and Revised Rule for Physician Assistants

The Colorado Board of Medical Examiners carries out several functions, the highest-profile of which is its disciplinary function. The numbers are in for disciplinary action outcomes for fiscal year 1996-1997 (July 1- June 30), and they show a slight drop (110 from 112) over the previous FY figures for total disciplinary actions taken.

Of a total of 110 disciplinary actions taken in FY 1996-97, seven resulted in revocation of licenses. The remaining actions are divided among the following: surrender of license or retirement - 15; suspension with or without probation - 23; probation (without suspension) or practice limitations - 23; letters of admonition - 33; licenses granted with probation or limitations - 8; licenses denied after hearing - 0; and, injunction or stipulated agreement - 1.

During FY 1995-96 of 112 actions taken, only two resulted in revocation.

According to the Board's FY 1995-96 Activity Report, in addition to its high-profile complaint review and disciplinary functions, the Board spends considerable time and effort on other statutorily mandated responsibilities such as licensing new physicians, insuring that physicians on probation remain competent to practice safely, providing information to the public about the status of physicians' licenses, and regulation of various categories of non-physician practitioners.

During FY 1995-96, the Board issued 838 new licenses to practice medicine and 92 new certificates to physician assistants. According to the Board's FY 1995-96 Activity Report, approximately 12,500 physicians held active licenses to practice medicine in Colorado. An additional 2,500 physicians held inactive licenses, for a total of about 15,00 licensed physicians. Of that total about 9,370 had Colorado addresses. There were 674 certified physician assistants.

Changes in Physician Assistant Rule

The Board also publishes a newsletter, The Examiner, containing practice tips, changes in the law, and changes in its own rules and policies. Physicians supervising physician assistants should be aware of significant changes in the physician assistant rules involving supervision, which became effective August 1, 1997. The Board is making available an information/fact sheet discussing the changes.

Here are a few highlights of the revised rules which appear in the April 1997 issue of The Examiner; the previous use of various factors to provide guidance for the level of supervision required has been abandoned. The Board now regards supervision as something best left to the particular physician and PA in question. The rules create primary and secondary physician supervisory positions. Physicians may not supervise more than two PAs at any one particular moment in time. Supervising physicians must review the chart for every patient seen by a supervised PA no later than seven working days after the PA performed an act defined as the practice of medicine.

Except as to secondary physician supervisors (SPS), a licensed physician may delegate to a certified PA acts which constitute the practice of medicine only if the physician has filed a complying form with the Board. That physician then becomes the primary physician supervisor (PPS) for so long as the form is on file with the Board. The PPS is liable for acts by the PA which are unprofessional and acts by the PA which violate these rules. However, the PPS is not responsible if the PA was acting under the supervision of another PPS (who would also have a complying form on file with the Board), or if the PA was being supervised by an SPS.

A secondary physician supervisor (SPS) is a physician other than the physician whose name appears on the form filed with the Board, who supervises the PA at a particular moment in time. If the SPS signs the chart, as the SPS, for a patient seen by a PA, that physician is deemed to be responsible for any act by the PA defined as the practice of medicine, performed by that PA while being supervised by that physician. If, from the signature on the chart and all surrounding facts and circumstances, a physician has assumed the role of SPS, that physician assumes the responsibility for supervision of the PA, relieves the PPS of the supervisory responsibilities set forth in the rules, and assumes responsibility for the PA's unprofessional conduct and violation of these rules. However, absent a review and signing of the chart by the SPS, the PPS for that employer shall be deemed to have been the supervisor rather than the secondary supervisor, and the PPS is responsible for the practice of medicine of the PA.

A physician can become a PPS if he or she undertakes the supervision of a PA who does not have a PPS or a form on file with the Board. That physician then

(Continued next page)

(Revised PA Rules *continued from pg. 2*)

assumes the responsibilities of a PPS, and is subject to the two PA limit.

A PPS may also be an SPS for two additional PAs, but at no particular moment in time may a physician supervise more than two PAs. A PA shall not have more than one PPS for each employer, even if the employer is a hospital system or HMO.

This summary is general. The rule itself and the Board's discussion, which will be mailed to all PAs, are the best source for full understanding of what is now expected of physicians supervising physician assistants.

CACME to initiate statewide domestic violence projects

The recent, successful domestic violence conference held in Conifer, "Domestic Violence...The Mountain Communities Respond" (*Colorado Medicine, May 1997, pg. 186)* generated a model for future community-wide efforts. The Colorado Alliance for Continuing Medical Education (CACME) has made a commitment to initiate similar, community-wide programs to address the problem of domestic violence. Each member will work within their communities to: 1) educate physicians about identification and referral of domestic violence victims and perpetrators to existing local resources; 2) create outcomes measurement tools; and 3) involve other community members to create resource networks and long term, community-wide protocols to address this problem.

CACME is a state association of continuing medical education professionals. The Colorado Medical Society has been an active participant with CACME for several years, and will prove resources and assistance for the development of these projects. If any of you would like to join in this undertaking or wish to have more information please contact: Mary Fletcher, CFMC, (303) 695-3399 or Lorraine Heth, CMS, 1-800-654-5653, x2409 or 930-0409. If you are interested in CACME membership, please contact: Nancetta Williams, Centura/Penrose-St. Francis Health Services, (719) 776-5184.

> "Each of us must make a personal commitment to say loudly and clearly that family violence is a scourge and that it will continue to plague this society until we demand it be stopped. Even then, we will not root out this cancer until it is viewed, not just as a woman's issue, but also as a man's issue and as a community's shame. When all people in Colorado feel the same way about this issue as domestic violence advocates do, then we will experience 'true' success."
>
> *—Bill Ritter, Denver District Attorney*

(Malpractice *cont. from page 1*)

action was $6,638 ($9,300 in 1995 dollars). By 1995, the cost had risen to $19,346 — more than double the adjusted 1985 cost.

- Typically, it requires $2.00 to deliver $1.00 in compensation to the injured party. That means attorneys are getting a large share.
- Approximately $737 million was spent in 1995 to defend meritless claims.
- One of the fastest rising costs in the defense of claims is the amount paid to "expert witnesses."

The PIAA is a trade association of more than 50 professional liability (medical malpractice) insurance companies owned and operated by doctors and dentists).

(BME *cont. from page 1*)

tion of the Medical Practice Act, the Board is obligated to carefully review any allegation of alcohol/substance use by on-call physicians which affects the quality of patient care. The medical board, at its discretion, may determine if a physician's use of a mind-altering substance or alcohol was unprofessional. In such an instance, the Board may conclude that a violation of the practice act occurred, and it retains the right to initiate disciplinary action against the physician's license to practice medicine.

CMS Med Fax

Colorado Medical Society provides the following listings of events as a member service only. Some events are approved for Continuing Medical Education credits. Information is provided by the sponsoring organizations. For more details, use the telephone contact at the end of the listing.

The International Skeletal Society 24th Annual Refresher Course
September 10-13, 1997
Santa Fe, New Mexico
(770) 641-9773

The Given Institute
Quandries in Health Care: Decision making, moral ambiguity and motivation
September 18-20, 1997
Aspen, Colorado
(970) 925-1057

Denver Medical Library
Informatics Fair '97: Computers in the physician's office– Overcoming the obstacles
September 25-27, 1997
Denver, Colorado
(303) 839-6670

1997 FAS Conference
Prevention & Mangement of Fetal Alcohol Syndrome and Prenatal Substance Abuse
September 25-27, 1997
Breckenridge, Colorado
Contact: Elizabeth Franz at (303) 756-8380

American College of Cardiology
14th Annual Santa Fe Colloquium on Cardiovascular Therapy
September 25-27, 1997
Santa Fe, New Mexico
17 Category 1 AMA CME credits
1-800-253-4636, ext. 695

Memorial Hospital
Sickle Cell Conference
Sickle Cell Disease: Pathophysiology, Treatment, and Prospects for Cure
September 26, 1997
Colorado Springs, Colorado
(719) 365-5675

Colorado Springs Osteopathic Foundation & Family Medicine Center
9th Annual Medical Ethics Conference
The Ethics of What's Driving Medical Care
October 9, 1997
Colorado Springs, Colorado
(719) 635-9057

Colorado Hospital Association
Accreditation Standards for Patient and Family Educ.
October 24, 1997
Englewood, Colorado
(303) 758-1630

Medical Education Resources, Inc.
Clinical Diabetes & Endocrinology in 1998
January 18-22, 1998
Snowmass/Aspen, Colorado
18 hours of Category 1 credit
(303) 798-9682 or 1-800-421-3756

American College of Cardiology
29th Annual Cardiovascular Conference at Snowmass
January 12-16, 1998
Snowmass, Colorado
1-800-253-4636, ext. 695

American Lung Association
17th Annual big Sky Pulmonary & Critical Care Medicine Conference
March 25-28, 1998
Big Sky Montana
(406) 442-6556

Send us your calender items.

If your specialty society or hospital is sponsoring a CME event or seminar which would be of interest to physicians in Colorado, have them send the information to: Event Calender, *Colorado Medicine*, P.O. Box 17550, Denver, CO 80217-0550. Please include information detailing program sponsor, date, location and phone number for more information.

Executive Director's Update



Sandra L. Maloney
Executive Director
Colorado Medical Societey

The Colorado Medical Society Saturday became the first such society in the nation to extend full rights and privileges of active membership to medical students.

That statement jumped out at me from a 1969 ***Denver Post*** story as I went through some old news clippings. I was impressed! I knew that Colorado had led in many organized medicine innovations, but this made me sit up straight and take a new measure of pride in Colorado Medical Society.

The article went on to say:

In an unprecedented action, the society's policy-making House of Delegates voted to establish a Student Component Society granting unrestricted membership to students at the University of Colorado Medical Center.

"We hope other medical societies will follow Colorado's lead in increased medical student involvement. We need these kids and their ideas," said Dr. William Covode of Denver, outgoing president who led successful efforts for the change.

Two CU medical students who spoke to the 113-member house hailed the society's action as "remarkable."

One of the students, Robert T. Henderson said the society's supporters at the medical school are "people who are not in agreement with the picket-carrying, self-proclaimed revolutionaries who form a large part of the Student Health Organization on many eastern campuses.

The Student American Medical Association (at CU) lies dormant thus far. But students are interested in a meaningful and representative voice in the organization to which they belong."

Kelley Skeff, another student, said the society's actions will mobilize the resources of medical students "'with the guidance and experience of practicing physicians."

This was a remarkable meeting on a number of counts, because at the same time the House of Delegates "passed a resolution to bolster delegate representation among interns and residents".

Wait! There's more. That same House replied to then-President Richard Nixon's mandate for a change in the draft laws. The House asked that medical interns be given credit for military service "by serving a like period of time in medical practice in an area, ghetto or rural."

I don't know if that resolution was acted upon by the White House (probably not, because they were busy planning "Watergate"). What struck me, first of all, was the genuine concerns of our CMS leadership in making such a recommendation. It was a darned good plan, too.

There were other developments at that meeting which were also standouts:

In the area of public health, the delegates passed resolutions to

- support a voluntary family life and sex education program at appropriate grade levels in the schools;
- encourage adequate sports medicine education "in every school that mounts a sports program;"
- endorse Rh factor screening for all obstetrical cases admitted to Colorado hospitals to help reduce infant mortality rates;
- condemn cigarette smoking;
- recommend proper labeling on all prescription drugs, and support mass clinics to administer Rubella vaccine.

Just this year Colorado's schools will not be allowed to admit a child who has not had vaccinations. It took our legislature a lot of years to finally see the wisdom of such a move, but now the law in Colorado is complete that all children must be vaccinated against Rubella, Hepatitis B, Polio, Hib, Measles, Mumps and DPT/DT . This will be one of the most effective, long-term health maintenance moves the Colorado Department of Health (and Environment) will have forged in decades. I am extremely pleased that Colorado Medical Society has forever been in the forefront of this movement.

And here's a bit of *deja vu* from 1969:

"The delegates also voted a $40-a-year dues increase to pay for architects' fees on a new health facilities building near the Presbyterian Medical Center in Denver. The building will house offices of the society and related health organizations."

Some things just don't seem to change; and it's good that CMS has **not** changed from being a bellwether medical society in the U. S.

Highlights of the Board of Directors Meeting - July 25, 1997

CMSA: Ms. Donna Foss presented the report in Ms. Stella Shank's absence. Ms. Shanks and Julia Gallagher, the CMSA AMA Delegate, attended the AMA Alliance Annual Meeting in Chicago this June. Ms. Shanks was elected to the AMA Alliance Nominating Committee. The new presidents-elect for CMSA are Sue Forester and Leslie Nathan. The Alliance has seen an increase in their membership over the past year. A total of over $20,000 was presented to CU Medical School from AMA ERF contributions. Ms. Foss thanked Dr. Painter for including the CMSA in our AMA Delegation Dinner during the AMA Annual.

AMA Delegation: Dr. Richert Quinn presented the report. Dr. Richard Allen has been reelected to the Council on Medical Education, and Dr. Mark Levine was an excellent chair for one of the reference committees. The Colorado Delegation submitted three resolutions to the AMA Annual this year.

Colorado Physician Network (CPN): Dr. David Martz presented his update via speaker phone. CPN continues to prosper, and market in various areas of the state. CPN is attempting to get Rocky Mountain Physician's Choice endorsed by the Colorado Medical Society, the Colorado Osteopathic Society, and the Academy of Family Practice.

Colorado Rural Outreach Program (CROP): Dr. Jack Berry introduced Mr. Ron Mirenda and Ms. Susan Landrum, of Mirenda & Associates, the new fund raising campaign consultants for CROP. They supplied the Board with an overhead presentation and a hand out showing their campaign plan.

Council on Legislation: Dr. Painter thanked Dr. Richard Allen, Chair, for the superb job he did during the legislative year. Dr. Allen reported that the Council on Legislation had their "end of the year" meeting last month, and a ***120 Day Newsletter*** was mailed to CMS Members recapping the legislative year. Dr. Allen stated that he would not continue chairing the Council on Legislation next year. Dr. Allen thanked CMS for its support

Next Meeting: Will be held prior to the CMS Annual Meeting on September 11, 1997, in Snowmass, Colorado.

LEGAL UPDATE

from Gelt, Fleishman & Sterling P.C.



A. Craig Fleishman, Managing Director

Antenuptial and PostNuptial Agreements - Protection and Security – Part I

Recent statistics show that 50% of all civil lawsuits are divorces. Given the statistical likelihood of this, men and women who have amassed significant assets or who have children from a former marriage are well-advised to consider an antenuptial agreement (premarital agreement) or a postnuptial agreement (one which is negotiated and agreed upon by the parties *after* marriage).

Antenuptial and postnuptial agreements are nothing more than an attempt to arrive at what the parties are willing to agree to be an appropriate allocation of marital assets in the event of divorce. In other words, if one has a valid antenuptial or postnuptial agreement and thereafter decides to divorce, it would not be necessary to hire attorneys or pursue court proceedings to attempt to negotiate or litigate who will get what marital property, whether maintenance should be awarded to either spouse, or whether one spouse should be paying the attorney's fees of the other spouse associated with the divorce proceeding. While Colorado law does not require the parties to such agreements to be represented by counsel at the time they sign such an agreement, it is wise to have both parties represented during negotiation and execution of the document. This eliminates the potential for either party to claim duress, undue influence, or lack of understanding of the document as a defense to the enforceability of the agreement at a later date.

Both types of agreements are intended as a means of preserving the status quo as to property interests which existed before the marriage as to the later appreciation of those assets. The agreements do not dispose of or divide property but, rather, fix the rights of the parties with respect to specific property regardless of the duration of the marriage. They also can be utilized to easily permit allocation of assets acquired during the marriage to one or the other party without the necessity of having a judge allocate those assets for the parties. In contrast, parties who do not have antenuptial or postnuptial agreements at the time of divorce are forced to negotiate separate agreements to resolve claims as to property interest which have matured because of the marriage status.

For further information please contact:

Gelt, Fleishman & Sterling P.C.
1600 Broadway, Suite 2600
Denver, CO 80202
(303) 861-1000

Kids and Guns Just Don't Mix...



Doctor, are you talking to parents about guns in the home?
Remember:
Separate guns and ammunition,
Lock up guns and ammunition separately,
Use trigger locks

If you keep a gun, empty it out, lock it up!

This message brought to you by the Colorado Medical Society, Task Force on Youth

For more information call Suzi Shevell at 303-930-0407 or 1-800-654-5653

Domestic Violence and Kids:
Some Signs, Some Help

"Sexual assault victims may make themselves intentionally unattractive through poor hygiene or eating disorders. . ."

A shattering statistic - when children are in the home and someone commits the crime of domestic violence, it is 70% likely a child will also be an immediate or eventual target. When four or more children are present in the home, the likelihood rises to 90%. The scars and impact of domestic violence are not limited to adults; children and youth are often the witnesses, victims and even sometimes the perpetrators of domestic violence.

At Project PAVE, counselors have been offering free long-term help for 8-18 year old victims and perpetrators of relationship violence for the last 10 years. We would like to offer physicians some of our clinical learning, some attitudes and behaviors to look and listen for when talking to a parent or child. **If a mom is talking about her kid(s) evidencing these signs, it's worth asking her if she sometimes feels unsafe at home, or if her children may be or feel under threat.**

Signs

- Youth from violent homes are psychologically abused; their self-esteem is very low, they are mired in depression or caught up in rage, often fluctuating between the two.
- They have poor social skills, are isolating themselves from friends and schoolmates, can't communicate the feelings they experience.
- They have a prevalence of behavior problems - they don't manage their anger well through appropriate expression. Boys especially externalize the violence they are witnessing; girls can tend to internalize the violence and become more self-destructive, though in the past 3 years we've seen more girls turning the hurt outward.
- They often seem overwhelmed, have an inability to focus and concentrate, they daydream and dissociate.
- They aren't adequately in touch with their bodies, may have out-of-body experiences. Sexual assault victims may make themselves intentionally unattractive through poor hygiene or eating disorders in an attempt to dissuade the perpetrator.
- They may have other issues about nurturance and food.
  The child may have sleep disorders, including bedwetting.
- They tend to have below average school achievement.
- They may evidence impulsivity and anxiety, seem to have their "arousal antennae" cranked way up, so that the slightest brush against them at school or the most reasonable correction sets them off.
- They may act out sexually, or abuse substances; the former to gain attention and human contact, the latter to self-anesthetize.

Help

A physician can be extremely instrumental in breaking the cycle of violence that tends to repeat itself in violent families - **if you are willing to intervene, the grandchild's generation can be violence free.**

DO

- Find a quiet, private place to talk to the child.

Domestic Violence and Kids

(Continued)

- Set a time to get back to the kid, or refer to professional support personnel. Project PAVE offers free services to young victims or perpetrators, ages 8-18; SafeHouse Denver offers a group for 4-7 year old victims. Parent groups are also available. PAVE's number is 322-2382.
- Listen carefully, let them talk openly about the situation. Try to set aside pressing pre-occupations.
- Rephrase important thoughts or disclosures for clarification, **using the young person's vocabulary.**
- Tell the youth there is help available, and they are strong and brave to talk about these issues.
- Reassure the kid you will do your best to help protect and support them.
- Take a positive approach to the problem.
- Separate the person from the behavior when commenting on the situation. Even when a parent, step-parent or mom's boyfriend may have been violent, do not run the offender down with the kid. It makes the kid defensive and like a tattler, even though the child may be outraged by the behavior.

DON'T

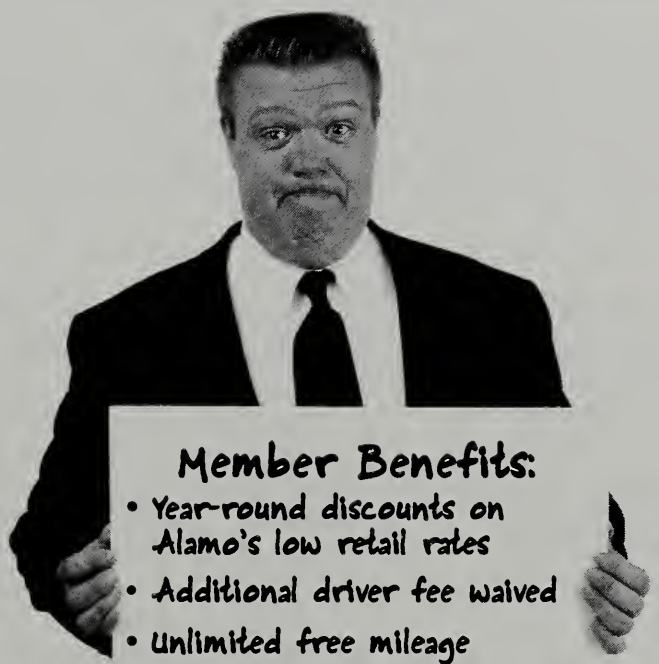
- Promise confidentiality when you may not be able to deliver.
- Express panic or shock.
- Make negative comments about the perpetrator or get into a moral lecture about the incident.

The interest, concern and intervention evidenced during interviews with a parent or child can be what makes the difference between this child getting help, or passing on the violence to siblings, schoolmates, neighborhood kids - even our own children and grandchildren. Be confident, ask the caring questions.

This article was written by Dennis Kennedy, Executive Director of Project PAVE. Some of the above information is adapted from DPS handouts on Child Abuse and Neglect.

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Remembrance of Dr. James F. Hoffman, Sr.

by James Wise, MD, and other friends in the Larimer County Medical Society.

Editor's Note: We are pleased to honor the request of the Larimer County Medical Society.

Dr. James F. Hoffman, Sr., was a fine internist and a longtime leader of the Fort Collins medical community. During the past year since his death, many of us have felt the need to share with the public and his many patients our great respect for him.

Dr. Hoffman, Sr., was born in Fort Collins June 16, 1912 and died in Fort Collins September 28, 1996, spending most of his life here. He is remembered by many of his former patients and physician colleagues as an extremely intelligent and informed physician, who had an unusual compassion and caring nature for all who were under his care.

In all, he served his community for 54 years as a physician and caring friend of both patients and colleagues.

Dr. Hoffman graduated from Fort Collins High School (very high in his class academically) in 1929. He was involved in many extracurricular activities and was Fort Collins' men's tennis champion for two years.

He attended Colorado A & M, now Colorado State University (CSU), in Fort Collins. Jim was an avid sports fan. He supported and attended the Aggies' events all through his life. The weather, the win/loss record, nothing kept him from going to support the Aggies. CSU made him an honor alumnus in 1970 in appreciation of all he did for the university.

Dr. Hoffman graduated from the University of Colorado School of Medicine in 1936, first in his class. He achieved many academic honors as a medical student. As recently as 1992, the CU Medical School presented him the Silver and Gold Award for being an outstanding alumnus. Probably his greatest achievement during medical school was to meet and later marry Maybelle Colborn, a nurse in graduate school at St. Luke's Hospital in Denver. They had been happily married 60 years at the time of Dr. Hoffman's death.

After medical school graduation, Dr. Hoffman worked at Denver General Hospital as an intern-resident for a year and a half, then he spent a year in the Public Health Service at Detroit's Marine Hospital.

He then pursued advanced training in pediatrics and internal medicine at the Children's Memorial Hospital in Chicago. While caring for children from the inner city, he contracted tuberculosis. He returned to Fort Collins for a year of bed rest, about the only treatment available for tuberculosis at that time. Dr. Hoffman did overcome his disease, but the aftermath was that he was unable to serve in the military service during World War II. He began practice in Fort Collins in 1941 and soon, due to his many colleagues and partners summoned for military service, he was one of the few physicians left to care for the people in Fort Collins during the war.



Dr. James F. Hoffman, Sr.
photo CMS Archives 4/7/79

From 1941 until he retired in 1995, Dr. Hoffman's practice grew, as the community grew from about 15,000 to 100,000. His practice was large and encompassed all things that needed to be taken care of at the time, i.e., pediatrics, internal medicine, obstetrics and surgery. No one was more pleased than Dr. Hoffman to see and welcome new specialists and sub-specialists to our medical community. He, along with Dr. Jackson L. Sadler, established our first coronary care unit in Fort Collins. Dr. Hoffman's son, James F. Hoffman, Jr., established the first cardiac surgery unit in Fort Collins.

Dr. Hoffman served the community throughout his career. He was on the founding board of the Fort Collins Children's Clinic, as well as the founding board of the Children's Court Appointed Special Advocates. Jim also served as an elder and a deacon in the Presbyterian Church.

Dr. Hoffman was a respected medical community leader and intellect, but it is not just for this that he is remembered. His thousands of patients, friends and fellow professionals remember Jim as a most dedicated, caring person, who was also a talented physician. This is his real legacy. He was the kind of doctor we all want for ourselves and our families when we are not well.

We all can gain from following Dr. Hoffman's examples and ideals. He did a great job on his watch and, with his inspiration, hopefully we will all come closer to doing as well on ours.

Here's Our Agenda

It's simple. It's straightforward. And it represents the future of medicine. The American Medical Association presented to the Republican and Democratic leadership this agenda for the upcoming 105th Congress. Your AMA membership strengthens our voice in support of physicians and their patients. . . and will enhance our efforts to turn these goals into reality.

- **Patient Protections** Above all, preserve the ability of physicians to act as advocates for their individual patients. Do not allow insurers to "gag" physicians or withhold medically necessary treatments from their patients.

- **Medicare Reform** Make the Medicare program solvent. Expand patient choice of plans. Allow future growth rates that cover patients needs. Retain special protection for the vulnerable and elderly.

- **Medical Education and Research** Continue to support medical education and research so we can find cures for killers such as AIDS and cancer.

- **Public Health Problems** Expand prevention and treatment programs to combat AIDS, drug abuse, smoking and violence. These problems cost billions of dollars and millions of lives.

- **Liability Reform** Enact meaningful liability reform to ensure fair compensation to patients with legitimate claims while eliminating excessive malpractice awards that lead to defensive medicine.

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Pointing the way:

CMS program year in review

by Chet P. Seward,
CMS Communications

"CMS will continue to assist physicians in mapping the proper course."

Once again the approach of the Annual Meeting heralds the end of another program year. CMS members can be proud that their society continues to lead the way on physician and patient advocacy issues in Colorado. Under the leadership of President M. Ray Painter, MD, promising programs like the Colorado Rural Outreach Program and the Physician Profile Project have grown to become hallmark undertakings for CMS. Improved communication tools like the web page and grass roots support networks linked via fax lines have increased the strength and stature of organized medicine. Advances at the state capitol have reinforced the Society's role as a source for qualitative information about health care. Similarly, numerous CMS committees have made impressive inroads into insurance reform and data collection which will alleviate "hassle factors" for physicians and improve quality care for patients around the state.

CROP

Colorado Rural Outreach Program, the CMS loan repayment program for physicians who are willing to work in rural areas, is becoming one of the most auspicious undertakings of the medical society since the formation of the Colorado Physician Network. The CMS Board of Directors' initial investment of $20,000 laid the foundation for the program, and CROP is well under way. A professional feasibility study was conducted and new consultants Ron Mirenda and Susan Holt Landrum were hired. Work has begun to achieve the capital campaign goal of $3.5 million. The time lines are in place and the project is on target. Workshops are also being developed to offer assistance to those people in rural communities responsible for recruiting physicians. Jack Berry, MD, is the Honorary Chairman of the capital campaign, Gary VanderArk, MD, is the Physician's Leadership Chair, and Robert Sawyer, MD, is leading the effort to attain foundation support for the capital campaign.

The promise of CROP has not only captured the eye of many in Colorado, it has also drawn the attention of other states that are studying it as a model for similar programs. Continued growth of the program hinges on physician involvement, and the project's success depends on whether or not rural Colorado communities receive the much needed health care they deserve. As members of CMS you are paramount to the livelihood of this valuable program. Please help build interest and support for CROP by talking with your friends and colleagues. For more information on CROP please call the CMS staff at (303) 779-5455 or 1-800-654-5653.

Physician Profile Project

Another program which has gained in popularity and importance over the past year is the Physician Profile Project (PPP). The project was developed in 1996 in response to a CMS resolution which encouraged the availability of useful, valid physician information. It seeks to facilitate informed decision-making by purchasers and continuous quality improvement by providers. The PPP, a joint venture between CMS, Copic and the Gadrian Corporation, has generated profiles for almost 3,900 Colorado physicians. Now in its second year, the project has begun the process of updating each physician's profile. These updates will occur annually during the month of the physician's birthday. The PPP has also created a second patient brochure, entitled Becoming a Better Health Care Consumer. These brochures cover: 1) the availability of the physician profiles, 2) what patients can do to help their physician help them (i.e. tell your physician about every prescription and nonprescription medication you take, etc.) and 3) common insurance terms. The profiles and brochures have helped to strengthen the decision-making process in the doctor-patient

(Continued next page)

relationship through better communication.

CMS Online

Creating better communication between the society and its members was one of the hottest topics during Dr. Painter's leadership conference in May of 1996. The CMS web page was launched as a result in December. Almost a year later, CMS Online has been redesigned and will be unveiled during the upcoming Annual Meeting. The new site will feature a sleeker look, better navigational control, an improved Members Only section with direct access to all of the CMS departments, and a search function which will allow you to examine the entire site for specific information. A host of other cutting-edge improvements are slated for the upcoming year. If you haven't "surfed" CMS Online yet, do so today by pointing your Internet browser to *http://www.cms.org*.

Legislative action

Communication with and grass roots support by members via the web and a fax network were two of the factors which led a banner year for CMS during the past legislative session. The Government Relations Department worked hard to represent your best interests, winning support for the passage of three important managed care bills. Consumer protections were instituted, along with procedures for the denial of benefits and standards of operation for managed care plans. The passage of an Alternative Medicine bill, which CMS successfully helped to amend, prompted the creation of the CMS Alternative/Complementary Medicine Task Force. A survey was sent to all members and the large number of responses has and will aid the task force as it researches the various modalities of nontraditional medicine in order to prepare a report on its findings for the next Interim Meeting.

Uniform disclosure

Ongoing dialogues with health maintenance organizations, indemnity insurers, employers and consumer groups also produced laudable results. Dr. Painter, Dr. Karlin and Dr. Sherman (Chair, CMS Managed Care Task Force) participated in meetings between the Division of Insurance and several consumer and carrier focus groups on uniform disclosure of health plan benefits. Legislation was passed directing the Division of Insurance to create a uniform, standardized disclosure form. Thanks to the diligent efforts of the Disclosure Working Group, the creation of a state form, which closely resembles the form created by the working group, is in its final stages. Public hearings are scheduled for this month, and the Division's favorable ruling is expected.

Medicare Competitive Pricing Project

Strong leadership and joint collaboration helped stave off the implementation of the Medicare Competitive Pricing Project in Denver. CMS joined with other health care groups in a lawsuit against HCFA to block the project on the grounds that it would decrease benefits and increase premiums for beneficiaries. The lawsuit was dismissed after HCFA agreed to cancel the project and meet with concerned parties before decisions about implementing another project are made.

Timely payment of claims

Complaints about timely payment of claims and concerns about drug formularies by members prompted Dr. Painter and the Managed Care Task Force to convene meetings with various managed care organizations. The lost/delayed claims meetings opened new avenues of communication and identified a number of problematic areas which both sides are working to study and rectify. Similarly, the Formulary Study Group was formed by the CMS/Colorado HMO Association Joint Committee to address issues in an attempt to make formularies more uniform and easier to use. A forum presented by this group will be held during the Annual Meeting.

Joint Data Project

The CMS Data Committee is cooperating with prominent managed care organizations (MCOs) on the Joint Data Project, chaired by Trish Byrns, MD. The project uses physician profiles generated by the MCOs to 1) help physicians understand how to interpret and utilize data which is being generated by MCOs about their practices and 2) use these data outcomes to improve quality of care.

Domestic violence

CMS has focused its patient advocacy strength on stopping domestic violence. An awareness drive was spearheaded with informational articles and special tear-out calenders to remind physicians about the warning signs, characteristics, and steps that need to be taken to put an end to this abuse. A CME conference in Conifer was so successful that it is being modeled for future CME events.

Medical indigence

Increasing access to health care for the medically indigent was also a spotlight CMS patient advocacy issue. Hundreds of health care leaders joined CMS President-elect Gary VanderArk, MD, in the state's first ever forum on medical indigence. Subsequently, the CMS Medical Indigence Committee was formed to explore ways to improve access. The Colorado Trust is working closely with the committee and has expressed interest by providing initial financial support for future programs.

Member services

Two new member service programs also took shape in 1997. CMS members can now purchase prescription pads on an "at-cost" basis. The HWC Group at Merrill Lynch now provides priority priced financial services to members through the Physicians' Financial Program. Financial seminars around the state are being run in conjunction with the program.

Road map for tomorrow

What path will health care in Colorado take next year? No one quite knows. However, CMS will continue to assist physicians in mapping the best course by promoting the art and science of medicine.

Copic Comment

by Jerome M. Buckley, MD
Chairman & CEO
Copic Insurance Company



Copic's Long-Term Care Solution for its Policyholders

Over the last two issues of Copic Comment, I have outlined the tremendous burden that long-term care and its financing present to society in general and to physicians in particular. On behalf of Copic's physician-directed Board, I am extremely proud to announce the introduction of Copic Care — the long-term care solution for Copic policyholders.

Beginning September 1, 1997, Copic Care long-term care insurance becomes part of the Copic medical professional liability insurance (MPLI) policy for all full-time policyholders and for part-time policyholders who have been insured with us for three years or more as of that date*.

Copic Care is insurance designed to cover the costs of qualified long-term care services, since these costs are typically not covered by Medicare or other health insurance plans. This revolutionary addition to your Copic MPLI coverage offers unique and valuable features, such as:

— Unsurpassed choice ofcare settings. Copic Care benefits cover qualified long-term care services regardless of whether they're provided in a nursing home, hospital long- term care unit, adult day-care center, hospice, Alzheimer's facility, or even in your home.

— Guaranteed issue, guaranteed renewal, and no pre-existing condition clause for base plan. As an eligible Copic-insured physician, you cannot be turned down for the Copic-provided base plan coverage, regardless of your health status. And, as long as you remain insured with us, your Copic Care coverage cannot be canceled.

— Inflation protection. Copic Care benefits will increase annually. 5% each year, compounded

— Unbeatable rates for coverage enhancements. As a member of Copic's 4,500-strong policyholder group, you will be eligible to enhance your coverage at rates unavailable to the general public.

— No elimination period for base plan. Copic Care pays from the very first day of your long-term care episode...not just minimizing but eliminating your out-of-pocket expenses No prior hospitalization is required.

— Spousal benefit-sharing option. For a nominal charge, you will be able to elect to share your long-term care benefits with your spouse.

— Federal tax qualification. Any premiums you personally pay for enhancements to Copic Care are deductible as a medical expense if you itemize, subject to IRS limitations. In addition, any benefits you receive through Copic Care are exempt from Federal taxation, subject to IRS limitations.

If you haven't already, you will soon receive your official Copic Care certificate and schedule of benefits outlining the details of this important coverage.

With Copic Care, the Board and staff at Copic have created a medical professional liability insurance policy with unparalleled features...without significantly impacting your premium or distribution.

Because you've told us that long-term care is important to you, we're confident that Copic Care will be the solution to meet these needs. We're hopeful, too, that the addition of Copic Care to your policy has again given us a chance to exceed your expectations, as we did with the Death, Disability and Retirement (DD&R) Benefit and the HIV Benefit.

On behalf of the Board and staff, I thank you for continuing to place your trust in Copic.

We welcome your questions and feedback at (303) 779-0044 or (800) 421-1834.

** A very few policyholders will not be eligible to participate in Copic Care. They include slot physicians, locum tenens physicians, retired physician volunteers, and part-time physicians who have been insured with Copic for less than three years as of September 1,1997.*

INTRAV

Wednesday, July 09, 1997

Bill Pierson
Colorado Medical Society
7800 East Dorado Place
P. O. Box 17550
Englewood, CO 80217-0550

Dear Bill:

It is with regret that I must inform you that Intrav can no longer promote tours with the Colorado Medical Society. It's funny how things work. There was a period there with the CME issue that it was questionable whether you would be able to continue your relationship with Intrav.

Bill, it is strictly a financial issue. We simply are no longer attracting enough of your members to sustain our program. In 1996 it dipped to an all time low of 12 passengers. I know as a businessman that you can understand this.

It certainly has not been because we have not had your full cooperation. You have always been willing to do whatever it took to maximize the possibilities. For that we all thank you.

Bill, I wish you the best. If there are any other questions that I can answer, please feel free to give me a call.

Sincerely,

Ric McCune

Ric McCune

7711 Bonhomme Avenue • St. Louis, Missouri 63105-1961 • (314) 727-0500 • Telex 6841028

New TB control regulations

by Richard Hoffman, MD, and Randall Reves, MD

"Rapid reporting is important because it triggers a contact tracing investigation by the local or state health department."

At the February 1997 meeting of the Board of Health, the regulations concerning the control of tuberculosis were modified. The new rules became effective on June 30, 1997 (Regulation 4 of 6 CCR 1009-1). This article provides a summary of the modifications.

The Board of Health made the determination that the emergence of multiple drug-resistant tuberculosis in this country and state dictates a coherent and consistent strategy in order to protect the public health from this grave threat. The underlying principles of the disease control strategy are as follows:

1) use of the most rapid and modern diagnostic methods by laboratories,
2) rapid reporting by physicians, hospitals, and laboratories,
3) full patient compliance with medical treatment, and
4) prevention of spread of tuberculosis in health care settings.

Suspected or confirmed tuberculosis has been required to be reported within 24 hours by physicians, hospitals, and laboratories for many years. Rapid reporting is important because it triggers a contact tracing investigation by the local or state health department, which may prevent life-threatening TB among high-risk contacts such as children or immunosuppressed persons. Highlights of important changes in the regulations are as follows :

- A laboratory may fulfill its requirement to report by submitting a sputum specimen from the patient to either the State or Denver public health laboratory. These laboratories use liquid culture media (BACTEC) and DNA probes and do not charge for the services they provide. The reporting requirement is not fulfilled if the laboratory submits an isolate from a culture or if the laboratory delays sending the sputum specimen.
- When a laboratory performs a culture that is positive for Mycobacterium tuberculosis, the laboratory must store the isolate or submit the isolate to either the state or Denver public health laboratory. If the patient is lost to follow-up and later located, the stored isolate may be useful for rapid and additional drug susceptibility testing in the event the first-line drugs cannot be used because of resistance or intolerance. Another use of the stored isolate is for DNA fingerprinting to determine how the bacteria is spreading or for evaluating possible laboratory errors due to cross-contamination.
- All persons with active pulmonary TB must receive directly observed therapy (DOT) for their disease. All medical providers and health care organizations are required to provide DOT for patients unless a variance for a particular patient from this requirement is approved by the State or Denver Public Health department. This rule is based on published recommendations of the CDC and American Thoracic Society (Treatment of Tuberculosis and Tuberculosis Infection in Adults

(Continued next page)

and Children; Summary recommendation #3 on page 1359; Am J Respir Crit Care Med 1994; 149:1359-74). Furthermore, a paper published by Weis et al demonstrated that universal DOT lead to significant reductions in the frequency of primary drug resistance, acquired drug resistance and relapse in Tarrant County, Texas (NEJM 1994; 330:1179-84), and Frieden et al showed that DOT resulted in better rates of completion of treatment and interruption of spread of TB in New York City (NEJM 1995;333:229-33). A study conducted by Denver Public Health demonstrated that the major cost of TB treatment is the cost of treating relapsed cases, particularly those with acquired drug resistance, and despite the greater initial cost of DOT, it is a more cost-effective approach than self-administered therapy under a doctor's direction (Chest 1997; 112:63-70).

How often is DOT administered? Not seven days a week for six months. DOT is given daily for two weeks and then twice weekly for 48 more doses (usually a total course of 26 weeks). One of the major advantages of DOT is the physician is immediately aware when non-compliance is occurring because the patient misses taking a scheduled dose of medication. With self-administered therapy, the physician may not be aware that non-compliance is occurring until clinical, radiologic, or bacteriologic relapse or failure occurs. The new rules require medical providers and health care organizations to report to the state or local health department within seven days the name of any patient on DOT who has missed one dose.

DOT requires planning with office staff and the patient. The state or local health department will provide assistance in this effort or even administer DOT, and this will fulfill the requirement for the medical providers and health care organizations.

- All hospitals and health care facilities providing in-patient treatment to persons with active tuberculosis disease shall notify the state or local health department immediately after plans are made to discharge the patient from the facility. The notification is intended to discuss the treatment plan for the patient and to assure adequate follow-up and coordination among providers so that the standard of DOT is met.
- All licensed hospitals and nursing home facilities shall maintain a register of the tuberculosis skin test results of health care workers in their facility, including physicians and physician extenders who are not employees of the facility but provide care to or have face-to-face contact with patients in the facility. The register may be needed for an investigation of possible nosocomial transmission. Except for very low risk facilities*, current CDC guidelines recommend that physicians who engage in direct patient care have an annual (or more frequent) TB skin test (*"very low risk" is defined in: Guidelines for preventing the transmission of Mycobacterium tuberculosis in health-care facilities, 1994; MMWR 1994; RR-13; pg 14). For non-employee physicians, most facilities are complying with this rule through the physician credentialing process.

A complete copy of the rules may be obtained by calling 303-692-2700. This article was prepared by Richard Hoffman, MD, State Epidemiologist, Colorado Department of Public Health and Environment, and Randall Reves, MD, Director of the Denver Metro Tuberculosis Clinic, Denver Public Health, Denver Health and Hospital Authority.

Colorado Physician Network, Inc.

Bold New Moves

Call 1-888-238-6060 for more details



by David M. Martz, MD
President CPN

Sometime between the writing of this article in mid-August and its publication in early September, CPN and RMHMO will be announcing a bold new move that will dramatically change the role of physicians in managed care in Colorado.

We are integrating the overlapping strengths of four organizations with similar core values to provide a combination of services that will more effectively meet the needs of those whom we serve.

The result of this consortium may include:

1. A dramatic increase in the number of "covered lives";
2. The expansion of our physician panel to provide the degree of choice demanded by health care purchasers in this era;
3. The establishment of a multi-faceted product line capable of meeting virtually all of the needs of the health care market;
4. The implementation of inter-related services to practicing physicians in Colorado.

This will provide the opportunity to accelerate the fulfillment of our vision of the past two years.

The public announcement of the program and its participants is expected in early September. You should receive a special mailing outlining the details: watch for it.

The responsibility--and challenge--to "Make it Happen" is at hand at last! Join us now in this Bold Move for Health Care in Colorado!!

Definition of Screening Services

by Grant Steffen, M.D.
Medicare Medical Director for Colorado

The distinction between screening and diagnostic services is one of nonbenefit and benefit.

Dr. Steffen shared the following definition with the members of the Carrier Advisory Committee at their August 21, 1997 meeting. It is being reprinted here to clarify an area of long-standing confusion.

Marilyn Rissmiller
CMS Dept. of Health Care Financing

Because screening can be a medically appropriate service, but one that is not a benefit nor covered by Medicare, the clinician needs to be able to distinguish screening from (for lack of a better phrase) diagnostic services. What follows is an attempt to define screening so that the clinician can better make this distinction. This definition does not claim universal application (a public health worker may have a different one) but is offered as a definition to serve the purpose of distinguishing between screening and diagnostic services *for the purpose of resolving Medicare issues.* The method by which the definition is made will involve defining what screening is and what is not, given that the boundaries of a concept are made more clear when both sides of the boundary are described.

Summary of the issues:

1. **Screening services** are those used to detect an undiagnosed disease where early detection may prevent harm, and where the patient has no signs or symptoms of the disease.
2. **Diagnostic services** are those used to manage a known disease or to evaluate symptoms and signs in order to make a diagnosis.
3. **Testing the preoperative patient** in the absence of signs or symptoms is considered screening, regardless of whether or not an undiagnosed disease may increase the operative risk.
4. **Testing a patient for an infectious disease** when there has been a recent and significant exposure to that disease is a diagnostic service.
5. While both diagnostic and screening services may be appropriate, screening services (except for screening mammograms and Pap smears) are not covered by Medicare.

Discussion of the issues:

A **screening service** for Disease X is one that is performed for a patient who has neither symptoms, findings (physical or laboratory), or any past history of Disease X. The purpose of this service is to determine if the patient has Disease X so that medical care can begin, the aim being to reduce or prevent damage. The characteristics of Disease X that justify screening include its incidence in the general population, the probability that the medical care will be effective, and the risk of not treating. The characteristic that distinguishes screening from diagnostic services is neither risk (one appropriately screens for and treats diseases of low and high risk) nor effectiveness of care, but rather the probabil-

ity of the disease occurring in the general population. This probability is low in contrast to that in the population for which diagnostic services are given.

A **diagnostic service** is one done for a patient who has the disease (the probability is 100%) or who has symptoms or findings that suggest the disease at which the service is directed. The probability that this patient with these symptoms or findings has the disease is much higher than that for the general public. Thus, the characteristic that distinguishes the screening service from the diagnostic service is the probability that the patient has the disease, high to 100% for the diagnostic services, and low for screening services.

This claim for probability as the distinguishing feature raises at least three issues.

1. **Preoperative testing** to detect and evaluate a disease that may be made worse by the surgery is diagnostic if the patient has the disease, screening if the patient doesn't. Thus, a preoperative chest film on a patient with COPD or an EKG on a heart patient are diagnostic, but screening if the patient has no condition for which these test are relevant. While the risk of surgery in the Medicare population may be higher that in the general population, risk is not the distinguishing characteristic for a diagnostic test, and does not allow the claim that these tests are not screening and should therefore be billable to Medicare as diagnostic.
2. **Family history -** the person with a family history of Disease X has a higher probability of having or getting that disease than the general population, presuming that Disease X is to some degree inherited. Harrison's *Principles of Internal Medicine* describes chromosomal disorders and Mendelian disorders as resulting from one to a few chromosomal abnormalities. These disorders will be usually identified before age 65. In contrast, the "multifactorial disorders", e.g., essential hypertension, result from multiple genetic and environmental factors and may arise after 65. Still, the probability of a multifactorial disorder occurring in the patient with a family history of it is much lower than it is in the patient with a clinical presentation compatible with that diagnosis. It is obviously impossible to list all probabilities for all the inherited and noninherited diseases and then divide the list into screening and diagnostic. However, this division is conceptually sound (based on relative probabilities). Thus, for the purpose of resolving Medicare issues, services aimed at detecting a familial disease in a patient *without* symptoms or findings of that disease are considered screening.
3. **Exposure to an infectious agent** - a person with a recent and significant exposure to an infectious agent may have no symptoms or findings that suggest infection. Still, with a recent (the incubation period hasn't ended) and significant exposure, the probability of the patient having this infection is much higher than that for the general population. This probability depends on how contagious the agent is, but in any event, this testing is considered diagnostic and not screening.

The services that may be either diagnostic or screening include evaluation and management services (E/M), clinical laboratory tests, physiologic tests (ECGs, EEGs, etc.), and imaging studies. There are many reasons for performing a service, and so, in distinguishing between screening and diagnostic services, one needs to recognize at least two different uses of "reason".

First, a **"justifying reason"** is a reason that results from accurate data and logical analysis of the data. Thus a history of bloody stools plus a confirmatory positive occult test justify a colonoscopy. An **"explanatory reason"**, one that merely explains why but does not justify an action, may involve incomplete or inaccurate data and either faulty or no logic. Thus one may claim that the CBC and Chem 19 tests were ordered because the patient's chief complaint (over the phone) was fatigue, a symptom without a diagnosis. But in the absence of a history and examination (when done properly, these will give a diagnosis in the great majority of encounters), this reason, the need to make a diagnosis, explains but does not justify the lab tests.

Reason for performing or ordering a service or test:

1. **Symptoms*** - The patient's symptoms suggested a significant medical problem which was not resolved by the history and physical examination, and the service in question may give an answer.
2. **Signs*** - On physical examination, the physician found a significant and new abnormality which may be explained by the service ordered.
3. **Past History* -**
   A. Past symptoms, no longer present, may require reevaluation.
   B. Past abnormal physical findings, no longer present, may require reevaluation.
   C. The patient had a disease which may be asymptomatic but requires periodic monitoring.
   D. The patient was taking a drug or some other therapy that required periodic monitoring.
   E. The patient was in the postoperative period of a diagnostic or therapeutic procedure, and a service was ordered or given to monitor the patient's progress or to assess possible complications.
4. **Screening** - None of the above conditions apply, but because a disease may have no early symptoms or signs, and because early diagnosis may improve the clinical outcome, a service to rule in or out that diagnosis is ordered.
5. **Liability** - Though none of the above reasons apply, the physician may wish to limit liability (defensive medicine) and so performs the service.
6. **Error** - The physician or an assistant ordered the wrong test by mistake.

(Continued next page)

Definition of Screening *(Continued)*

7. **Habit** - Though none of the above apply, the physician has always performed or offered this service.
8. **Faulty Reasoning** - The physician believed that a test might have some bearing on the clinical picture, but this belief was incorrect.
9. **Curiosity** - The physician or patient "just wanted to know", and none of the above apply.
10. **Patient Demand** - The patient is more than curious. He or she demands that the test be done because of some belief (perhaps well founded) that it will benefit him or her.
11. **Financial Gain** - Because the provider is paid for the service, and in spite of the fact that none of the above reasons applies, the service is performed.

The first four reasons, and perhaps the fifth, are justifying reasons. **Medicare considers only the first three reasons as meeting the requirement of "reasonable and medically necessary", and so qualifying for coverage.* These reasons identify those services that are diagnostic. While screening is good medical practice, it is not covered by statute, except for the screening mammogram and Pap smear.

Reasons 6 through 11 are not justifying reasons, i.e., they do not justify the service as either diagnostic or screening. They explain why the physician ordered or gave the service (I goofed, I always do it, I was mistaken, I was curious, the patient insisted) but do not justify the service.

Evaluation and Management services, like tests, may be either diagnostic or screening. The "yearly exam" of, or any visit by an asymptomatic person whose past history contains none of the items listed under 3. above, is a screening service (or perhaps given for one or more of the Reasons 5-11).

To summarize, in considering the screening/diagnostic distinction, Medicare covers those services that are medically necessary, defined by Reasons 1-3, and labeled diagnostic services. They address either known or highly probable diseases for the patient for whom the service is given. Screening services are defined by Reason 4, and address diseases of low probability for the patient. The remaining seven reasons identify services that are neither diagnostic nor screening and have little (Reason 5) or no justification.

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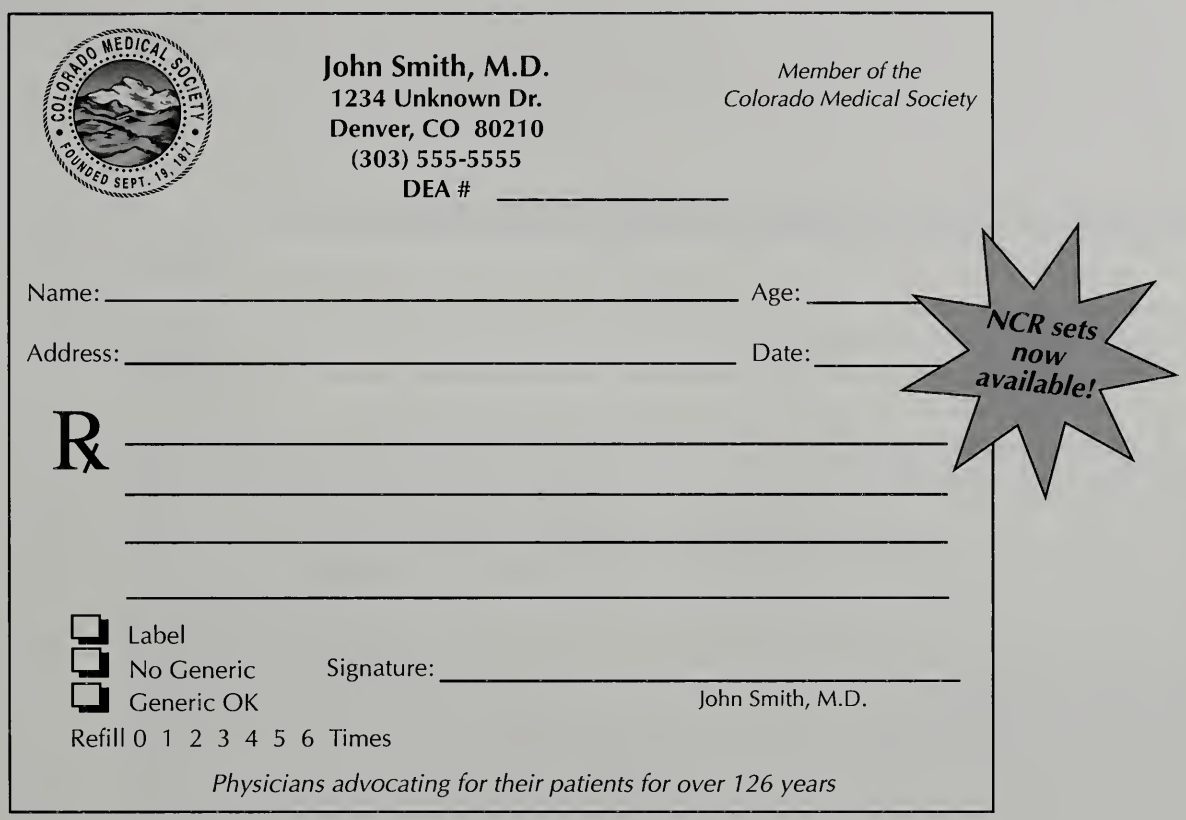
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Archives



John L. Lightburn, M.D.
Historian
Colorado Medical Society

"LA GRIPPE" with a vengeance

"We are in the throes of a visitation that should, at least, be good for our souls. For nigh two decades.... increasing control of important diseases has merged into something like braggadocio which has exalted our abilities to an eminence lacking a sure foundation."

Henry Sewall , M. D., in a paper read before the Denver Medical Society on December 17, 1918

In the June, 1918 issue of *Colorado Medicine* there appeared the following news item: "The Lake County Medical Society met in regular session April 18, 1918 at the home of Dr. H. A. Calkins..... Dr. Calkins' paper, "Pelvic Abscess, an Unusual Case" was well received.... Dr. Griffith reported a case of influenza that simulated typhoid fever. Dr. A. J. McDonald spoke of two cases of similar nature." Three cases of influenza. Nothing unusual. Dr. Calkins and his colleagues were going about their daily rounds, caring for the health of their community. They hoped the war would end soon so that their colleagues could return home and relieve the doctor shortage.

They had no inkling that seven months later, their community of Leadville would be in the throes of a devastating epidemic.

About a month before the Armistice and the end of the fighting, a disease known as the Spanish Influenza appeared in the capitals of Europe and rapidly spread to the rest of the civilized world. In just a few weeks, it had spread over the United states. There had been a severe epidemic in 1893, but this pandemic was unlike any previous "flu" epidemics. This was explosive and deadly. World wide, it killed twenty million people in less than two years, more than the war had killed in over four years! In the United States there were over 500,000 deaths attributed to the disease. In Dr. Calkins' town of Leadville, two of the mortuaries reported each having over 30 bodies awaiting burial. In the mining camp of Silverton, they ran out of coffins and were forced to bury the dead wrapped in blankets. In Cripple Creek, it was reported that the bodies were stacked outside the mortuary. Most of the mining towns of the state had similar experiences with mines and mills closed for lack of men well enough to keep them open. Some communities tried to control the spread of the disease by quarantining railroad workers and visitors, and limiting the number of mourners at funerals to two. Other communities in the state placarded the homes and isolated the patients. But no matter how energetic were the efforts to control the disease, the epidemic continued unabated. In October of 1918, the city council of Denver passed a series of ordinances that drastically limited public meetings. Schools were closed, public meetings were prohibited, theaters were closed, church services were limited and social gatherings were discouraged.

Efforts to control the disease were hampered by the failure to understand the etiology. In an editorial in the November, 1918 issue of *Colorado Medicine* Dr. William H. Crisp wrote: "The abundance of our ignorance concerning disease has been beautifully demonstrated by the epidemic of the so-called Spanish influenza. For the army of bacteria, there has seemed to be neither a western front nor an eastern front of effective resistance. Since the first ravages of the disease were reported from the fighting lines and from the Spanish capital last spring, the epidemic has become a pandemic, spreading probably to every civilized region which has maintained social and commercial intercourse with the European centers of origin.... There has been on the whole a rather striking lack of agreement ....as to the bacteriological basis of the disease." He doubted that Pfeiffer's bacillus was the cause and argued strongly for the pneumococcus or the streptococcus as the cause. Addressing the apparent conflict between the proponents of the pneumococcus versus the streptococcus, he suggested that the difference was "merely another demonstration of the essentially homologous character of the pneumococcus and the

streptococcus.... it is entirely practical to believe that the virulent organism which has traveled so rapidly .... has been almost as protean in its form and morphological reactions as its pathological influence on the human body." Why did he fail to mention virus? Although knowledge of the "filterable virus" was new, Henry Sewall used the term in his discussion the epidemic two months later.

It was serendipitous that Dr. Sewall was a visiting physician at Denver County Hospital from October 1 to November 30 when the epidemic first became manifest. At the December, 1918, meeting of the Medical Society of the City and County of Denver, he presented a "Brief Study" based on those two months service with the collaboration of Dr. J. R. Huxley, resident physician and Dr. Morris Katzman, pathologist. Here are some excerpts which provide a picture of the contemporary medical scene of 1918. Before presenting his clinical data, he scolded the society for its failure in "organization and coordination of individual knowledge, talents and energy." Then he said, "...will not society sooner or later call upon the medical profession for an accounting of its stewardship? You may have patience to consider whether we, the County Medical Society, have done our full duty to our patients and society when we fail to organize our forces against influenza." After chastising his audience, he presented a meticulous account of his clinical experience with the beginning of the epidemic. "We all know that ...certain cases from the outset will defy all remedial efforts of the physician while another . . . group gets well in spite of anything the doctor does or leaves undone."

"No signs of the epidemic appeared on the hospital records until the week of October ...(when)... nine cases diagnosed as pneumonia were admitted ....the advance guard of the influenza victims." He paid tribute to the hospital administration who "met the emergency immediately, resolutely and without vacillation. The two brightest wards in the hospital, one for men, the other for women, were cleared of their ordinary occupants. ..well adapted for isolation, relegated solely for the care of influenza cases. As soon, as cases of the disease appeared among the nurses, the commodious children's ward was emptied and devoted to the care of sick nurses."

"The total number of cases attributed to influenza during this period (October and November) was five hundred and thirty-five ....The number of deaths recorded at this same time was one hundred and seventy-one, giving a mortality rate of slightly less than thirty-two percent." This was the same rate reported in the army camps. "Beginning with the week ending October 5, the weekly admissions were 9, 74, 77, 48, 36, 70, 60, 85, 74." He saw no prospect for an early end to the epidemic. "Of the one hundred and seventy one deaths recorded, autopsies were made in but eight cases. This humiliating admission of the waste of material for scientific instruction is proof, if proof were needed, that no business administration however competent, is alone sufficient to develop the full good of a hospital." Some of us may have entertained a similar thought. What would Henry Sewall say today?

He then warmed up to his subject giving a detailed description of the gross pathological findings. Because "like syphilis, it imitates many conditions but is identical with none" he could not present a typical history. "Nevertheless, there are a few feature that are of interest.... The great majority of patients were between twenty an forty years. Physical robustness was the outstanding rule. The splendid bodies of the sick men seemed but to invite the touch of the destroyer." Of the fifty-three nurses who worked in the hospital, twenty-seven became ill and were hospitalized in their special ward, usually within two days of the onset of symptoms. Although some were very ill, there were no fatalities. "The explanation that seems most satisfactory lies in the period elapsing between the onset of the disease and the beginning of complete bed rest..... Most of the ward cases had been sick for a week or more before admission to the hospital."



Denver County Hospital, circa 1901.

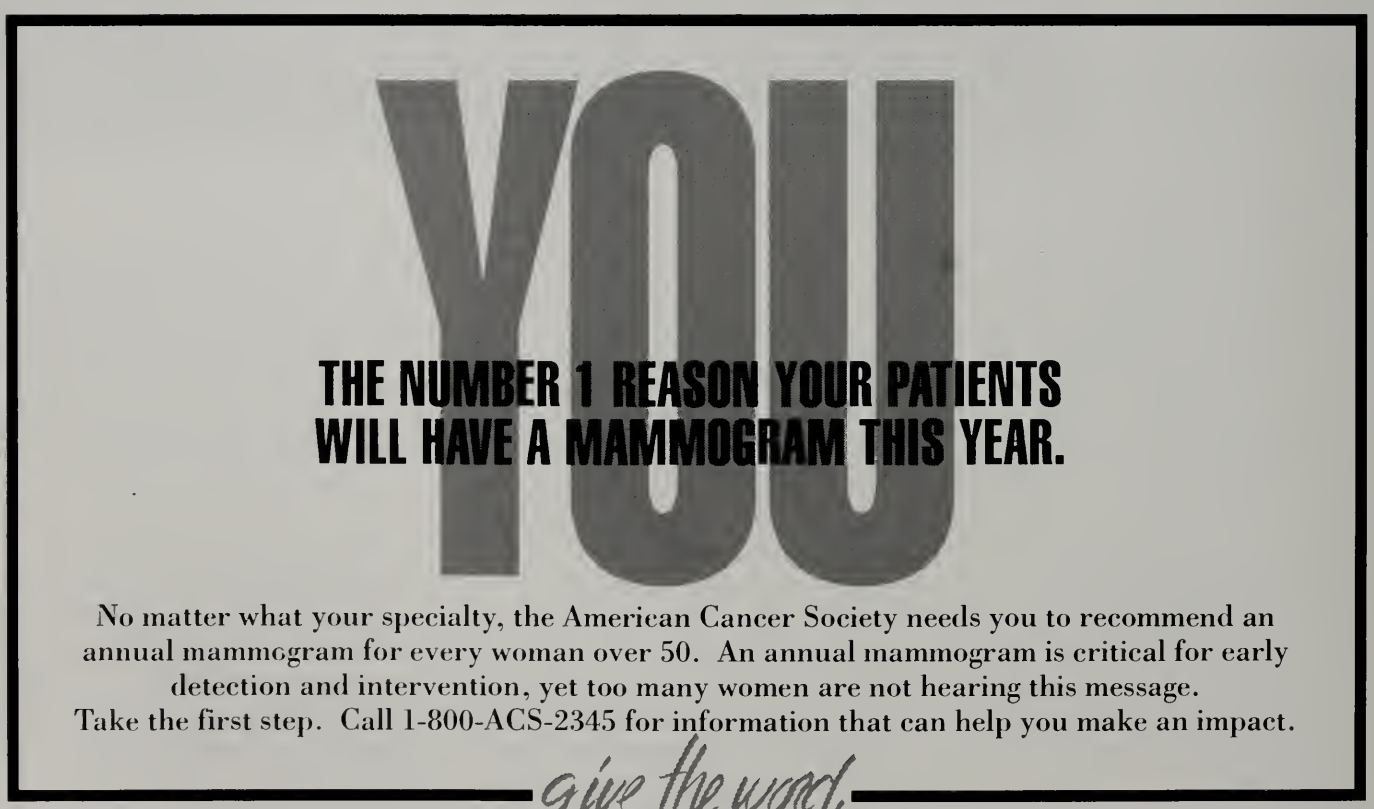
Dr. Sewall's meticulous and detailed approach to physical diagnosis is beautifully described in his paper, and we are given a clear picture of medical practice of that time before the advent of "high tech" medicine. Here are some excerpts to illustrate: "One of the most characteristic findings in influenza ... is apprehension by auscultation of showers of fine crepitant rales which seem near the ear with inspiration....

(Continued on following page)

Archives *(Continued)*

I have spent many hours trying to determine the exact sequence of auscultatory signs which mark the transformation of a congested but functioning lung into one in which tissue condensations appear and gradually develop into more or less massive consolidations.... It is my personal conclusion that while the clinical diagnosis of pneumonia in influenza is probably usually correct, clinical exclusion of the pneumonic process is next to impossible.... But the practical difficulties of physical diagnosis reach their climax when the examiner tries to make the discrimination between pulmonary consolidation and pleural effusion. Given a chest with a flat percussion note, feeble tactile fremitus and diminished voice and breath sounds, ordinarily one would confidently expect the aspirator to withdraw fluid from the chest. But in influenza the insertion of a needle ...may prove a dry tap. On the other hand, a flat percussion note over a chest that on auscultation shows superficial respiratory crepitation would seem to indicate consolidation, but in such a case I have withdrawn a quart or more of fluid.... It would be possible to explain these findings from the data of pathological anatomy, but it must be granted that they depart from ordinary clinical experience..... In conclusion, one of the striking and most important of the clinical aspects of influenza is the unexpectedness of its changes for worse. A number of times, I have left patients apparently well, holding their own, and on my visit next morning found them beyond my power to aid." Dr. Sewall's experience at the county hospital was not unlike that of physicians practicing in the other hospitals. For example, in the week ending October 26, there were 217 influenza deaths in the city of Denver, and in the first two months of the epidemic, there were over 1,100 influenza deaths in the city. Although treatment was largely supportive and empirical Dr. Maurice Katzman and his laboratory at the county hospital developed a vaccine of killed hemolytic streptococci which he gave to 900 patients of the county hospital and also distributed to the staffs of the other hospitals of Denver where an unknown number of patients were given the vaccine with unknown therapeutic results. Dr. Katzman followed up the 900 patients at the county hospital and was certain that the vaccine was of benefit.

So the doctors of that period, their ranks depleted by departure of many colleagues to the war, but aided by volunteers and medical students, spent long hours battling an unidentified enemy with imperfect knowledge, courage and dedication. Their persistent efforts to solve the puzzle and collect and record data were important steps toward the modem medical knowledge we use today. The Spanish Influenza disappeared almost as rapidly as it has appeared, and with the end of the war, the profession could return to other concerns such as pelvic abscesses, glaucoma and scarlet fever.



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9Health Fair

". . .this year's 9Health Fair gives a strong reading of the public's interest in their own health care. . ."

The 1997 9Health Fair, which was held April 5 - 13, had over 45,000 participants at the 128 sites across Colorado. Following are the results of these contacts:

38,861 persons had a blood chemistry analysis, and of these, 493 received a follow-up telephone call to alert the person to the values.

217 PAP smears were performed, and of these, 36 were found to be abnormal.

14,233 men were tested for PSA, and of these over 1,000 were found with an abnormal level between 4 and 10.

Of the 38,861 blood-chemistry analyses, approximately 14,000 persons were selected to receive a follow-up letter concerning the test indications.

In the event that abnormal readings or test results are indicated by a screening performed through 9Health Fair sites, the person is advised of the reading or result and advised to see his/her physician or, if the person has indicated that he/she has not been seeing a physician, the person is urged to contact a physician through a local hospital.

Following receipt of this report, Colorado Medical Society physicians asked the following questions and received these answers from Kris Gonzalez, RN, BSN, Medical Coordinator for 9Health Fair:

Q. What were the participants notified by telephone of "Alert Values" told? Is there a script?
A. *Participants with alert values are told to notify their health care provider. If the participant has no provider, he/she is referred to generic community resources: public clinics or hospital of choice, no direct physician referrals. Medical information given to participant is generally limited to information in the pamphlet which is sent with their lab results. Calls are made by 9Health Fair Medical Coordinator or other experienced Registered Nurse. There is no script.*

Q. How were the "abnormal pap smears" managed?
A. *Calls encouraging follow-up were made to ladies with PAP results outside of normal limits. Then letters were sent along with the actual pathology report. A follow-up letter has since been sent, reminding the women that they should have had further evaluation and asking them to send back a Response Form.*

Q. May we have a copy of the follow-up letter?
A. *Enclosed is a multi-page follow-up letter designed for a fictitious participant who tripped all our "triggers." All follow-up letters contain the cover letter and the comment page. All participants with blood pressures of 140/90 or greater receive the "blood pressure" page. Other sections are generated only if those comments are indicated by that participant's abnormal screening results.*

Q. May we have a more specific definition of "Cancer/Cardiovascular."
A. *Cancer triggers are those defined in the follow-up letter. Cardiovascular refers to those participants with systolic blood pressure of 140 or greater or diastolic pressure of 90 or greater.*

Q. Did physicians receive copies of PAP smear and other Alerts"?
A. *Participants are instructed to forward results to their physician. PAP screening pathology reports and/or [preliminary lab reports ("Alerts") are faxed or mailed to physicians if 9Health Fair Medical Coordinator receives written authorization to release the information.*

Colorado Medical Society physician advisors have made specific recommendations to the 9Health Fair in wording of the follow-up letters and questionnaires, specifically, that the reference to "health care providers" be changed to "physician(s)" throughout.

Attendance at this year's 9Health Fair gives a strong reading of the public's interest in their own health care, and as a result of the numbers involved, Colorado Medical Society has recommended to the CMS House of Delegates that the endorsement of the 9Health Fair by Colorado Medical Society be continued.

by Marilyn Rissmiller, CMS
Department of Health Care Financing

Balanced Budget Act of 1997

President Clinton recently signed the Budget Reconciliation Bill that was submitted by Congress, thus begins the Balanced Budget Act of 1997. Following is a summary of physician/patient issues:

Physician Payment Issues

The total Medicare physician payment reduction is projected to be $5.3 billion over five years. (This number is considerably less than the cuts faced two years ago when the GOP balanced budget plan called for $12.6 billion and the President's plan called for $15 billion in physician spending reductions.)

- **Conversion Factor** - Beginning January 1, 1998 there will be a single conversion factor for all services (primary care, surgical, non-surgical). This conversion factor will be equal to the 1997 primary care conversion factor ($37.13) with an increase based on the weighted average of what the update of the three separate conversion factors would have been.
- **Anesthesia Conversion Factor** - As of January 1, 1998, the anesthesia conversion factor will be 46% of the single conversion factor rate for all other physician services. (Except that any adjustments made for changes in work, practice expense or malpractice relative value units will not be considered in calculating the anesthesia conversion factor.)
- **Practice Expense Relative Value Units** - The deadline for HCFA's implementation has been extended for one year, and then the practice expense relative value units will be phased in over a four year period. However, the final bill included a "down payment" provision for redistributing some of the work expense dollars to primary care services beginning January 1, 1998. It is possible that this language may be removed in the technical rewrite of the bill.
- **Annual Update Formula Changed** Beginning in 1999 the annual updates will be limited to 93%-103% of the Medicare Economic Index. A target growth rate tied to the gross domestic product will determine the amount of the actual update.
- **Drugs and Biologicals Administered in the Physician's Office** - Reimbursement will be reduced 5% as of January 1, 1998. The amount payable will be 95% of the average wholesale price of the drug.
- **Graduate Medical Education (GME) Funding** - The Indirect Medical Education adjustment has been reduced from 7.7% to 5.5%, and GME payments will be carved out of the AAPCC (the amount used to determine payments to Medicare managed care plans). There will also be incentive payments to hospitals for reductions in the number of residents.

Beneficial Additions/Changes

The Balanced Budget Act includes the addition and expansion of Medicare benefit for some preventative services.

- **Screening Mammography** - Beginning January 1, 1998 a screening mammogram will be

(Continued next page)

"The total Medicare physician payment reduction is projected to be $5.3 billion over five years."

Balanced budget *(Continued)*

paid annually for women over age 39. This service will not be subject to the patient's deductible.

- **Screening Pap Smear and Pelvic Exam** - As of January 1, 1998 Medicare will begin paying for *both* a screening pap smear and a screening pelvic exam every three years. For women of childbearing age who have had a pap smear during any of the previous three years that indicated the presence of cervical or vaginal cancer or other abnormality, or for women who are at high risk of developing cervical or vaginal cancer, Medicare will pay for an *annual* screening pap smear and pelvic exam.
- **Prostate Screening Tests** - Will be covered annually for men over the age of 50 beginning January 1, 2000.
- **Colorectal Cancer Screening Tests** - Will be paid annually beginning January 1, 1998. The tests included under this provision are: fecal-occult blood test, flexible sigmoidoscopy, and in the case of an individual at high risk for colorectal cancer, a screening colonoscopy.
- **Diabetes Self-Management** - Outpatient self-management training and education services will be covered when the physician certifies that such services are needed under a comprehensive plan of care related to the individual's diabetic condition. In addition, coverage for blood-testing strips and glucose monitors has been expanded, without regard to the individual's use of insulin. These changes are effective July 1, 1998.
- **Extension of Influenza and Pneumococcal Vaccinations** - Medicare coverage of these preventative vaccinations is extended until the end of fiscal year 2002.

Medicare Part C = Medicare+ Choice Program

The Medicare population will now have even more options. In addition to HMOs and CMPs (Competitive Medical Plans), the Medicare+Choice Program will offer the possibility of PPOs, PSOs, private FFS and a MSA demonstration project.

- **PSOs** - The Medicare+Choice Program includes language which will hopefully open the way for the development of PSOs able to underwrite the Medicare package.
- **MSAs** - There will be a four year demonstration project for up to 390,000 Medicare beneficiaries who will be able to purchase MSAs coupled with a $6,000 high-deductible plan.
- **Private Contracting** - Physicians can pursue private contracts with persons who would otherwise be eligible for Medicare benefits. The Medicare program balance billing limits do not apply to these private contracts. Physicians cannot be providing emergency or urgent care and must submit a signed affidavit to HHS indicating that they do not intend to submit any claims or receive any reimbursement through the Medicare program for a two year period (i.e., opt out of Medicare completely for two years). The private contracts between the physician and the patient must be in writing and include specific consumer safeguards including disclosure of fees.
- **Patient Protections** - Anti-gag language applicable to the Medicare program is included, as well as, the prudent layperson definition of a medical emergency.

Other Changes

- **Fraud and Abuse** - New civil monetary penalties were added for "kickback" activities. (Note: The balanced fraud and abuse definitional safeguards contained in the Kassebaum-Kennedy bill from the last Congress were *not* taken away.)
- **Home Health** - Funding was transferred from Part A to Part B.
- **Electrocardiogram Transportation** Payment for transportation of electrocardiogram equipment (HCPCS code R0076) will be reinstated for services furnished during 1998.
- **Nurse Practitioner (NP)/Clinical Nurse Specialist (CNS)** - Effective January 1, 1998 Medicare will pay for all covered services provided by NPs and CNSs without direct physician supervision regardless of place of service (for those services within the scope of their state license). The restrictions concerning rural vs. urban areas have been removed. In addition, the allowables for such services will be set at 85% of the physician's fee schedule amount.
- **Physician Assistant (PA)** - Effective 1/1/98 Medicare will pay for all covered services provided by NPs and CNSs without direct physician supervision regardless of place of service (for those services within the scope of their state license). The restrictions concerning rural vs. urban areas have been removed. In addition, the allowables for such services will be set at 85% of the physician's fee schedule amount.
- **Diagnostic Information** - When a physician orders an item or service from another entity the physician must provide the patient's diagnostic information. For example, if the physician orders three blood tests from an independent laboratory, he must provide the lab with the patient's diagnosis for each of those tests at the time the order is placed.
- **Clinical Lab** - Medicare will begin regional administration of clinical laboratory services (other than those provided in the physician's office) no later than July 1, 1999. Nationally there will be no more than five carriers to process all clinical lab claims. Medicare will implement national coverage policies, which identify the medical conditions for which a laboratory test is reasonable and necessary, beginning no later than January 1, 1999 for all clinical diagnostic laboratory tests.

Please contact Marilyn Rissmiller in the CMS Health Care Financing Department at 779-5455 or 1-800-654-5653 if you have any questions.

RUMINATIONS

(**def:** chewing again what has been chewed slightly and swallowed; to **REFLECT**)

*by **Bill Pierson**, Managing Editor*

Wait a minute! .... just who is the victim?

How many domestic violence occurrences are there which go unnoticed because the man or wife is afraid to let the matter be known, in fear of physical retaliation?

How many domestic disputes occur in which the "victim" is the wrong person?

I served on a jury recently in a case of assault. Only a charge of third degree assault, but the charge was brought by the husband against the wife. He alleged that she had thrown a "full-size Mason jar" at him, striking him in the right hand, causing him serious pain and discomfort for some days. His 17-year-old son (by a previous marriage) was the first prosecution witness. The son is a collector of swords and other feudal weaponry. He testified he and his father were watching a videotape on a Saturday morning in April. The snow was deep outside their trailer home and his stepmother (the alleged assailant) said she was leaving but soon announced her car was stuck in the snow. The son and father helped her dig out, and an argument ensued between father and wife about a dent she had reportedly put in his car without telling him about it.

The son testified that the argument progressed into the garage where the wife allegedly threw two oil cans at the husband (later disproved) and then climbed into the rafters where she said she was going to stay, refusing to come back into the house. The husband reportedly went back into the house and sat down to watch more of *"Dr. Who"* on the telly.

A short time later the wife came into the house saying she couldn't stay out there because it was so cold; she was going to go to bed, to which the son made an offhand (under-the-breath type) comment. She then came back out and passed into the kitchen where (he said) she didn't seem to know what to do. Finally, he said, after the exchange of some comments she picked up a glass candy dish and threw it at him as he sat in a recliner in front of the TV. She then followed this with the Mason jar, but the husband jumped from his recliner to defend his son, and the jar struck him in the hand.

The husband told the court that he had been a student of some martial art since 1963 while he was in the Far East. He still practiced this in some form of "black belt" competition, or whatever. He testified in a very dramatic manner the details of that April Saturday argument, saying she was verbally attacking his 19-year-old son (who was not there to defend himself) and his younger son was verbally defending his brother who had come under criticism in relation to the dent in the car. The father said he saw the candy dish sail through the room and he rose to stop the attack on his son when he was struck, trying to fend off the flying object as he intervened. When that happened, he testified, she lunged at him whereby he wrestled her to the floor and placed a "carotid hold" on her throat to subdue her and calm her (for her own safety, he said).

What emerged from this was a four year path of male taunting, threatening, abusive relations, with the woman often cowing to the threats of exercise of martial arts or feudal weaponry. No, **she** was the victim; he was the one the police believed when they made their report. He was the one who carried the four years of abuse to the peak when he filed an assault charge against her, thinking she ought to spend a few months in jail for domestic retraining purposes (my presumption). She was the one who had earlier filed a restraining order against him. She was the one who in self defense threw the glass objects at the 17-year-old macho copy of the father when he stood in the living room and threatened her with a sword. She was the one who could never mount a proper defense to the three males who dominated the 10' by 50' trailer home with detached garage. She was the one who had finally been goaded to the point where she could no longer control herself and made a pitiful attempt at declaring her independence.

We ask the question of ourselves, "Why didn't she leave?" The answer in this case was simple to see, there in the court room: she was afraid for her life.

Yes, **she** was the victim... afraid of retaliation, afraid for her life!

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Benjamin Cordova, Ed.D named new executive director of CHPP

The Colorado Health Professions Panel (CHPP) named Benjamin L. Cordova, Ed.D as its new executive director.

CHPP is a not-for-profit health professions policy and grant-making foundation. The mission of the Panel is to advance the creation of an integrated system that develops adequate types and numbers of health professionals with the knowledge, skills and attitudes that meet the health needs of Colorado communities.

Cordova earned his doctoral degree in counseling psychology and higher education. Most recently Dr. Cordova has been the director of BLC Group, Inc., a professional medical and counseling service in Denver that provides psychological and medical services to patients with mental illness, developmental disabilities and rehabilitation and geriatric needs.

High touch meets high tech at 1997 Informatics Fair

The Fifth Annual Denver Medical Library Informatics Fair will explore the theme "Computers in the Physician's Office: Overcoming the Obstacles.

Scheduled for September 24-27 at the Denver Medical Library in Columbia Presbyterian/St. Luke's Medical Center the event will feature a wide variety of activities from lectures and workshops, to exhibits and interactive seminars. Attendees will be able to immerse themselves in the world of information systems, meeting skilled professionals who not only understand the technology that has changed the face of medicine, but understand the implications.

Key speakers include Jeremiah Gutman, JD, Chair, Committee on Privacy, ACLU, presenting "Tensions Between Confidentiality and the Need to Know;" Sue Lytwyniuk, Vice President, Business Operations, Pacificare, presenting "Electronic Data Interchange in Colorado: The Next Millennium;" Kent Christopher, MD, presenting "Automated Outcomes Management; The Asthma Demonstration Project;" and Bill Braithwaite, MD, PhD, Senior Administration Advisor on Health Information Policy, presenting "Congressional Mandate for Medical Record Standards."

Panel topics include: Legal Pitfalls of Electronic Medical Records; Believers vs. Skeptics – Paperless Records; State of the Art in Voice Recognition; and Case Studies in Electronic Medical Records.

Workshops will cover how to wade through the jargon and technobabble to become a knowledgable computer buyer. Commercial displays and educational presentations will cover every aspect of medical computing.

Further information and Fair registration packet can be obtained by calling the Denver Medical Library at (303) 839-6670.

Medicare E&M Documentation Guidelines updated

Updated Medicare Evaluation and Management (E&M) Documentation Guidelines become effective January 1998. The updates, which will be distributed this fall, are the first changes since their release in 1995. The Medicare E & M Documentation Guidelines give physicians the opportunity to familiarize themselves with the criteria the Medicare carrier will use to evaluate their records should questions arise concerning the appropriate use of the E & M codes.

The updated guidelines include substantial changes in the documentation of the examination. In particular:

- The content of the general multisystem examination has been redefined, and its documentation requirements changed.
- Content and documentation requirements have been added for 10 organ systems. The single organ specific examinations include: cardiovascular; ear, nose and throat; eyes; genitourinary (female); genitourinary (male); hematologic/lymphatic/immunologic; musculoskeletal; neurological; psychiatric; respiratory; and skin.

Training and distribution will be coordinated by specialty societies. Contact CMS or your specialty society for more details.

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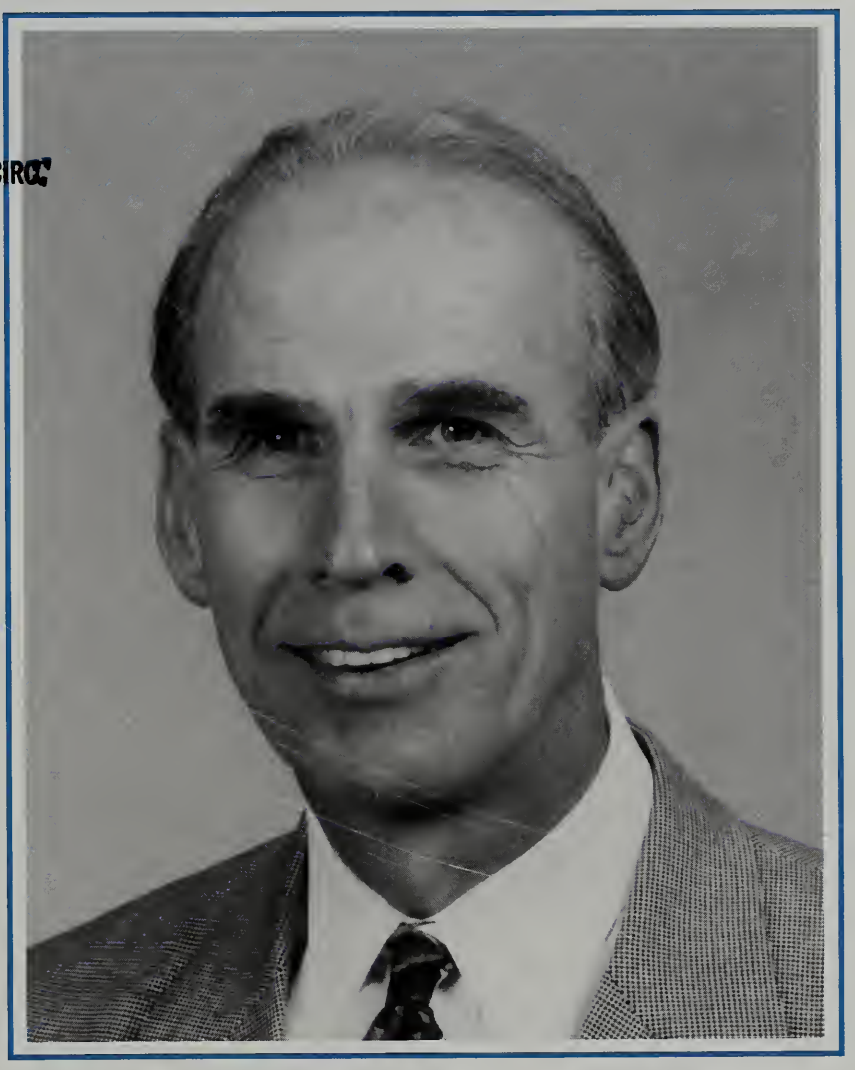
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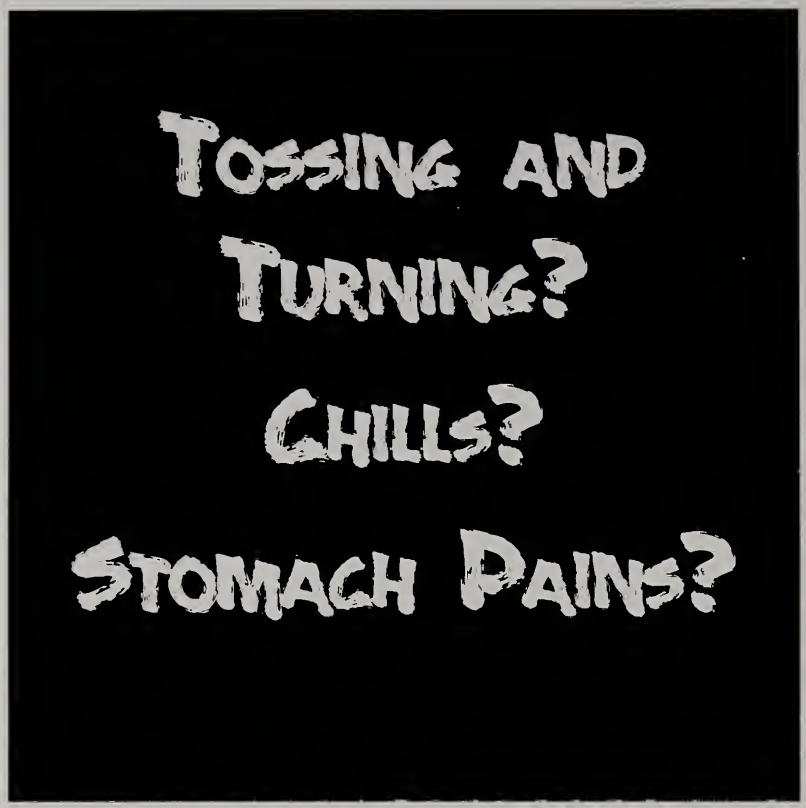
Meet the Conductor"



Gary D. VanderArk, M.D.
President, Colorado Medical Society
1997-1998

This Issue:

The meeting's over; let the music begin ..... page 357
Special Insert: 1997-98 Directory Appendices ..... page 370
Terminal Care: One physician's view ..... page 366
"A little old lady with a nice smile" ..... page 386



You must not be insured by Copic.

Worried about all the changes managed care is bringing to health care delivery? Copic understands your concerns. To ensure that they're heard by people who can act on them, Copic established the Managed Care Task Force in 1993. The Task Force comprises Medical Directors from Colorado's leading managed care organizations. Since its establishment, the Task Force has improved communication between managed care organizations and health care providers on issues such as delays in referral authorization, use of out-of-state reference laboratories, and release of patient records to utilization reviewers. The format is simple — everybody talks...everybody listens...and everybody works toward an acceptable solution. The Managed Care Task Force — just one of the ways Copic is helping Colorado's health care community adjust to managed care.

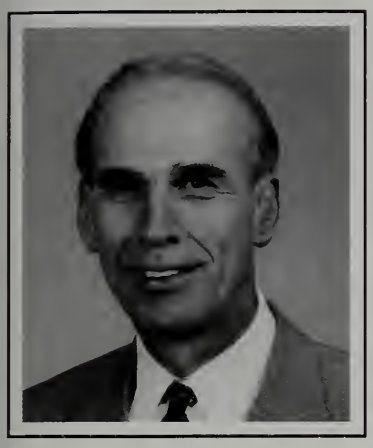
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COLORADO MEDICINE

October, 1997 Volume 94, Number 10



Cover Story

A symphony of physicians installs a new president and turns its ear to the community.

See page 381

In This Issue...

357 **Let's all get together and push.**
Gary D. VanderArk, MD
President, Colorado Medical Society

364 **Domestic violence and children** – many people focus on the adult victims of abuse, however children that are exposed to vio lence also face adverse reactions. Physicians can help these young victims.
B.B. Robbie Rossman, Ph.D.

366 **Physicians and terminal care** – a doctor critically assesses this socially charged issue.
Gerald D. Reilly, MD

370 **SPECIAL INSERT**
Appendices for the 1997-1998 edition of the CMS Medical Office Resource Book.

380 **What about AIDS?** A new exhibit at the Denver Museum of Natural History may be the perfect educational tool to teach your patients about this disease.

381 **1997 CMS Annual Meeting Proceedings**

390 **Medicare Documentation Guidelines** for the new single system examination may affect your practice. Here's what you need to know.

Departments

357 President's Letter
361 Executive Director's Update
370 Colorado Physicians' Network
383 Board Highlights
386 Archives
390 Health Care Financing
391 Copic Comment
392 Medical News
393 Classifieds
394 Ruminations

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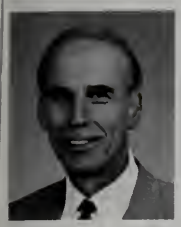
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President's Letter



Gary D. VanderArk, MD
President, 1997-1998

President's Inaugural Address to the Colorado Medical Society House of Delegates, September 13, 1997

Give me liberty or give me death, cried Patrick Henry! Our nation was founded on the principal of liberty. We told our Mother nation across the sea that we would not have taxation without representation. We demanded and won our freedom. The individualism advocated by John Locke lies at the core of American culture. We believe in the dignity, indeed the sacredness, of the individual. Anything that would violate our right to think for ourselves, judge for ourselves, make our own decisions, live our lives as we see fit is not only morally wrong, it is sacrilegious. Our highest and noblest aspirations not only for ourselves but also for those we care about, for our society, and for the world are closely linked to our individualism. America's creed has always been self-fulfillment and the right to be left alone.

Alexander Hamilton, our first Secretary of the Treasury, was the Rush Limbaugh of his day and the spokesperson for the conservative individualist. Conservatives hold the rights of private interest above the public good. Americans, from the beginning, tended to act with far greater personal initiative and self-reliance than our European ancestors.

Then, along came Ronald Reagan with his neo-capitalist vision of shared values in family, work, neighborhood, peace and freedom. His rhetoric evoked feelings of private virtues. President Reagan felt that the primary aim of government was to safeguard the peace and security necessary to allow self-reliant individuals to pursue their largely economic aims in freedom.

Two bastions of individualism stand out in American history. One is ithe cowboy and the other is the physician. The code of the American West has been that if you could see the smoke from your neighbor's chimney, it was time to move west. The epitome of the individual hero has been the cowboy. The cowboy rode off into the sunset like Shane or the Lone Ranger. His destiny was to defend society without ever really joining it. The cowboy of literature and the movies has unique and individual virtue and special skills. Will Kane, the hero of High Noon, abandoned by the cowardly townspeople saves them from an unrestrained killer, but then throws his sheriff's badge into the dust and goes off into the desert with his bride.

The connection of moral courage and lonely individualism is even stronger in the medical profession. Medical students are raised to be aggressive, competitive, self-assertive scientists. Among physicians there is an example of the supremely egotistical, antisocial, self-centered individualist: the neurosurgeon. When that aneurysm in your brain bursts, who do you want to fix it — some sniveling, hand-wringing, feely, touchy committee or a self-reliant egomaniac? In my day job as President of the Colorado Neurological Institute, I am expected to keep butterflies flying in formation.

There is another side to American history. It is the side of the public good. For the United States was also founded with an emphasis

"The connection of moral courage and lonely individualism is even stronger in the medical profession."

on equality and commitment to community. Certainly, the history of the colony of Massachusetts is a story of community. Thomas Jefferson is seen as the champion of the liberal populist side of this debate. Jefferson from the beginning of the Revolution pressed vigorously for widespread democratic participation both as a check on the ambitions of leaders and as vital education in the spirit of republicanism. And the history of America has been of involvement. Getting involved is the American way. Our early history in this country is epitomized by the town meetings of New England. The traditional institutions of the town expressed a classic vision of what such a community is and what it must continually strive to become: a self-reliant congregation created and maintained by the voluntary cooperation of self-reliant individuals.

So medical science and technology have improved the prospect of cure, but have de-emphasized medicine's traditional caring func

(Continued)

tion. Doctors are losing the public's respect and are increasingly seen as self-indulgent, affluent, pleasure seekers. There is an increase in commercialization of medical practice. Managed care has led us to be seen as mechanistic, commercial and soulless to our patients. It is no longer fashionable to think of medicine in terms of morality. The probable apocryphal story is told of a HCFA (Health Care Financing Authority) economist who, when asked "What about the theory that human life is priceless"? replied — "We have no data to support that".

Although medicine has always been recognized as a profession, we are dangerously close to becoming a trade. The professional recognizes his or her responsibility to society, whereas the tradesman is concerned about doing a job. A profession means a life to which we are called. A professional is involved in a moral enterprise. A tradesman is involved in doing work for which money is paid. We have committed what the Republican forefathers of this nation felt was the cardinal sin - - we have put our own good as individuals and as a group ahead of the common good.

Well, as we come to the close of the century and this millennium, where does the Colorado Medical Society fit in all of this? I hope that this meeting has given you strong evidence that we are going to buck the trend. As pilot of your ship for the next year, I want you to know that the rudder is going to steer us to port. I told you one year ago that I had a vision and I can assure you that it is even clearer today. Last year, I quoted from a plaque found on an inner city London church that says:

"A vision without a task is just a dream
A task without a vision is drudgery
But a vision with a task can
accomplish great things."

A vision means having a clearer mental image of the future. Our task within our profession is to put an end to the trend toward individualism and to build community in Colorado. Leland Kaiser and the speakers at our educational program see the physician playing an increasingly important role in societal transformation. Now is the time for physicians to become architects of healthy organizations and healthy communities.

The theme of this meeting has been **community.** I think Henri Nouwen, one of the biggest heroes in my life, understands best what community means. Father Nouwen, a Catholic priest who was chaplain at a center for mental and physically handicapped people, describes community as being like a large mosaic. He says, "Each piece seems insignificant. One piece is bright red, another cold blue or dull green, another warm purple, another sharp yellow, another shining gold. Some look precious, others ordinary. Some look valuable, others worthless. Some look gaudy, others delicate. As individual stones, we can do little with them except compare them and judge their beauty and value. When, however, all these little stones are brought together in one big mosaic portraying the face of Christ, who would ever question the importance of any one of them? If one of them, even the least spectacular one, is missing, the face is incomplete. Together in the one mosaic, each little stone is indispensable and makes a unique contribution to the glory of God. That's a community, a fellowship of little people who together make God visible in the world."

Community is a combination of two words — common and unity. We do have some things in common and I think it is time to have some unity in our profession. Private vs. public are not mutually exclusive but two haves of a whole and two poles of a paradox. It is imperative that we work together to create and nurture one another. It is only through community that the individual can be fully realized. Let's turn down the rhetoric between specialists and primary care, between town and gown, between staff model and open IPA physicians. The CMS can be the vehicle towards physician community.

The AMA Principles of Medical Ethics states that "A physician shall recognize a responsibility to participate in activities contributing to an improved community". By community, they do not mean an association of people with vested interest. Community means the best the human spirit has to offer; the capacity to care and to share and to walk in someone else's shoes. Yes, physicians and the profession have a covenant with society to be advocates for the health needs of the community. We need to do that in three ways: First of all, we must promote the philosophy that health care is a basic human right; 2) Secondly, we need to promote public health in the widest sense of that term; 3) and, finally, we need to provide leadership on the question of how best to protect human life and enhance human dignity in a situation of limited wealth resources. Some call this rationing, but I, like the late Cardinal Bernardin, prefer the term - stewardship.

When I ran for President of this medical society, I said that my platform was one of access and accountability I think that we have already begun on the agenda of doing something in both of these areas.

In March at the CMS Interim Meeting, we sponsored a conference on caring for Colorado's medically underserved. It was a wonderful day attended by people involved in all aspects of health care. We were educated about the underserved population. Do you know that 87% of the 600,000 uninsured in Colorado are working? Do you know that 20% of children in Colorado who are eligible for Medicaid are not even signed up?

At that conference, we pledged to develop an action plan that will make a difference for Colorado's underserved. A coalition for health care access has been established. The Colorado Trust has asked permission to fund our activities. Governmental departments and agencies, legislators, insurers, foundations, business as well as providers are involved in this process. Enthusiasm is rampant and a feeling of universal optimism gives me a feeling that our action plan will

CMS Med Fax®

...a compilation of medically-related news briefs of immediate interest to the physician community occurring after ***COLORADO MEDICINE*** has gone to press. ***AT PRESS TIME...***

CMS Med Fax®
by Montgomery Little and McGrew, P.C.
legal counsel to the Colorado Medical Society

Interim legislative committee deliberates over mandatory no-fault auto insurance

The legislative interim committee which has been studying the high cost of mandatory motor vehicle insurance in Colorado over the past two months reached a consensus on which issues they will present to the full legislature during the upcoming session. At their September 24, 1997 meeting the committee decided that they will draft legislation on the following:

- Give insureds a choice in the level of benefit packages which they can purchase. Insureds should have the option of purchasing lower levels of liability insurance as well as lower levels of personal injury protection (PIP).
- Eliminate the statutory requirement for wage loss replacement coverage (which is now included as part of the PIP coverage) and make such coverage optional.
- Require insurance companies to offer deductibles for PIP coverage. (State law currently mandates deductibles for comprehensive and collision coverages.)
- Establish monetary penalties for insureds who select the preferred provider option (PPO) and subsequently go outside the PPO network.
- Prohibit "rating up" or refusing to insure a person solely because the person has not been insured for more than 30 days.
- Require that consumers be provided a disclosure of their coverage in plain language at the time of purchase.
- Clarify the statute to allow for the sale of group auto insurance.

(Continued on page 3)

Coming Next Month!

"ACCOUNTABILITY"

In the November issue of ***Colorado Medicine*** we begin a new monthly feature called "**Accountability**" and it will be a simple guide to physician accountability, outcomes measurement, methods and analysis.

Following the 1997 Leadership Conference, ***"Accountability and Accessibility,"*** there has been such an interest in the subjects that CMS President Gary VanderArk, MD, has assembled an array of experts and tools in these fields. In his introduction of the series, for instance, Dr. VanderArk stresses the importance of physicians being able to use the data gathered in outcomes measurements and, as he points out, "If we can't interpret the data, we can't use it to improve the quality of our care."

"ACCOUNTABILITY" will be presented in an understandable and enjoyable fashion that will profit the reader greatly in this new era of changes in healthcare. Colorado Medical Society is deeply involved in this subject. Through the 1997 Leadership Conference we have discovered that Colorado has a great deal of expertise on the subject. This feature is designed to share that expertise with you.

Watch for "ACCOUNTABILITY"
beginning in the November, 1997, issue of ***Colorado Medicine.***



Med Fax: Medico-Legal News

by Karen B. Best, Esq., an associate with the law firm of Montgomery Little & McGrew, P.C.

This column contains information concerning topics of general interest in the medical-legal field. For further information or help with specific problems, please contact Montgomery Little & McGrew, P.C.

Informed consent: How much do you have to tell the patient?

It's uncanny. Doctors being sued always remember explaining everything very carefully to their patients. Patients suing doctors don't remember a thing.

Putting aside for a moment the fact that it may go in one ear and out the other, what information are you legally required to disclose? The patient must be informed of 1) the nature of his ailment or condition; 2) the nature of the proposed operation, procedure, or treatment; 3) the alternative treatments available, if there are any; 4) the "substantial risks," if any, involved in undergoing the proposed operation, procedure, or treatment; and 5) the substantial risks, if any, involved in undergoing any alternative treatments available.

A "substantial risk" is any risk a physician knows, or a reasonable careful physician should know, would be significant to the patient in deciding whether to submit to a particular operation, treatment, or procedure. Some risks are clearly significant and must be disclosed. After the fact, any risk or complication that occurs can become a "substantial risk" in the patient's mind; "I would not have consented to that treatment had I known this could happen." It appears to be a wholly subjective standard, and in a malpractice case a patient can initially prove his case by merely demonstrating that he was not informed of the risk that occurred.

However, if there was a failure to inform, the physician will typically defend his conduct by calling an expert witness to establish that the physician's failure to inform conformed with the standards of professional practice.

As with other types of professional conduct, a physician's conduct in providing an informed consent is measured against an objective standard of what reasonable physicians practicing in the same field of practice at that time would have disclosed to the patient under the same or similar circumstances. This standard leaves room for the disclosure of some but not all risks associated with any given treatment. Thus, the failure to inform of a particular risk may not give rise to liability for malpractice, if the failure to inform conformed to the standards of practice.

A recent case illustrates the point. For the sake of space I have simplified the facts and ignored disputed facts to highlight the informed consent aspect only. In the course of treating a patient with prostatitis, Dr. P prescribed Septra. The drug cured the patient's condition almost immediately. However, while the patient was taking the drug, he experienced fever, chills, fatigue, and muscle aches. Several days after stopping the drug, he experienced a spell resembling a grand mal seizure. The patient claimed that Septra caused the seizure, and that Dr. P negligently failed to inform him of the risk of seizures from taking Septra. Both the patient and the doctor agreed that Dr. P had not warned the patient of the possibility of seizures from the use of Septra.

At trial, Dr. P called an expert witness who testified that the risk of seizure from Septra was insubstantial (extremely low) and therefore, under the applicable standards of the medical community, Dr. P was not required to inform the patient of that risk before prescribing the drug. The patient did not call an expert witness to testify that the standard of practice did require Dr. P to disclose the risk of seizure. In the absence of expert testimony supporting the patient's lack of informed consent claim, that claim was dismissed. On appeal, the Colorado Supreme Court upheld the dismissal.

Thus, although the rule requires the disclosure of information that would be important to the patient in deciding whether to undergo the treatment, the physician's conduct in providing that information is measured against an objective standard. Proving a lack of informed consent claim involves more than just your word against that of the patient.

CMS Med Fax

(No-fault cont. from page 1)

The committee rejected the adoption of a medical fee schedule and implementation of peer review procedures for all auto related medical expenses. However, there was at least one member of the committee who remains interested in these ideas and may draft such a bill individually.

CMS staff in the Health Care Financing Department and the Government Relations Department will closely monitor further developments as this committee meets again in late October.

CMS member elected President of Osteopathic Academy



Lawrence N. Varner, D.O., an orthopedic surgeon from Aurora, Colorado, has been elected President of the American Osteopathic Academy of Orthopaedics. Dr. Varner was inauguragted at the AOAO meeting in Atlanta, Georgia, on September 22, 1997.

Dr. Varner, a member of the Aurora-Adams County and Colorado Medical Societies, has been an active member of Colorado Medical Society since 1978. He is a graduate of the Philadelphia College of Osteopathic Medicine and has been active in the AOAO since 1991, serving as Secretary-Treasurer and 3rd, 2nd and 1st Vice President.

CFMC wins CHAMPUS/Tricare contract

The Colorado Foundation for Medical Care (CFMC) has been awarded a $2.3 million contract to provide services for the Department of Defense CHAMPUS/Tricare office located in Aurora, Colorado

CFMC, a medical quality improvement organization based in Aurora, bid for the work jointly with KePRO, a Harrisburg, PA, organization. The total contract is valued at $13.4 million. The new contract represents an expansion of the work CFMC has done for CHAMPUS. Since 1977 CFMC has served as medical consultant to CHAMPUS operations around the world.

As a subcontractor on the new contract, CFMC is responsible for the certification process for mental health facilities that wish to provide services to dependents and retirees of the federal government's uniformed services. In addition, CFMC is charged with providing medical peer review services to the CHAMPUS/Tricare Office of Appeals and Hearings.

CFMC specializes in utilization review, quality review and health care management programs. Founded in 1970, CFMC works in cooperation with the federal government, state agencies, local municipalities, commercial insurance companies and managed care firms.

New Officers and Board Members of the CMS

New officers for the CMS were elected and installed at the recent Annual Meeting. The 1997-98 Officers include: Gary D. VanderArk, MD, President, George W. Shanks, MD, President-elect, Robert L. Kruse, MD, Treasurer, Louise L. McDonald, MD, Speaker of the House, Sherri J. Laubach, MD, Vice-speaker of the House and M. Ray Painter, MD, Immediate Past President.

New CMS Board Members include: Alfred N. Carr, MD, Brian L. Johnson, MD, Nelson I. Mozia, MD, and R. Douglas Yajko, MD.

Reelected as Delegates to the AMA were M. Ray Painter, MD, and Mark Levine, MD. New Alternate Delegates to the AMA are Barbara Reed, MD, Jeremy Lazarus, MD, and Steven Thorson, MD. Dr. Lazarus won election after filling out a term to which he had been named in March, 1997.

CMS Med Fax

Colorado Medical Society provides the following listings of events as a member service only. Some events are approved for Continuing Medical Education credits. Information is provided by the sponsoring organizations. For more details, use the telephone contact at the end of the listing.

Colorado Hospital Association
Accreditation Standards for Patient and Family Educ.
October 24, 1997
Englewood, Colorado
(303) 758-1630

American College of Cardiology
29th Annual Cardiovascular Conference at Snowmass
January 12-16, 1998
Snowmass, Colorado
1-800-253-4636, ext. 695

Medical Education Resources, Inc.
Clinical Diabetes & Endocrinology in 1998
January 18-22, 1998
Snowmass/Aspen, Colorado
18 hours of Category 1 credit
(303) 798-9682 or 1-800-421-3756

American College of Cardiology
Cardiovascular Conference at Snowbird
February 11-14, 1998
Snowbird, Utah
18.5 Category 1 AMA
1-800-253-4636, ext. 695

Colorado Society of Osteopathic Medicine
Ski & CME Midwinter Conference
February 22-27, 1998
Keystone Lodge & Resort, Colorado
38 hours AOA Category 1-A, AAFP prescribed course hours; AAPA credits
Contact: Patricia Ellis (303) 322-1752 or 1-800-527-4578

Medical Education Resources, Inc.
Dermatology for the Non-Dermatologist
February 13-15, 1998
Breckenridge, Colorado
11 hours of Category 1 credit
(303) 798-9682 or 1-800-421-3756

American College of Cardiology
5th Annual Echocardiographic Workshop on 2-D Doppler Echocardiography at Vail
February 23-26, 1998
Vail, Colorado
18 Category 1 AMA
1-800-253-4636, ext. 695

American Lung Association
17th Annual big Sky Pulmonary & Critical Care Medicine Conference
March 25-28, 1998
Big Sky Montana
(406) 442-6556

Send us your calender items.

If your specialty society or hospital is sponsoring a CME event or seminar which would be of interest to physicians in Colorado, have them send the information to: Event Calender, *Colorado Medicine*, P.O. Box 17550, Denver, CO 80217-0550. Please include information detailing program sponsor, date, location and phone number for more information.

succeed.

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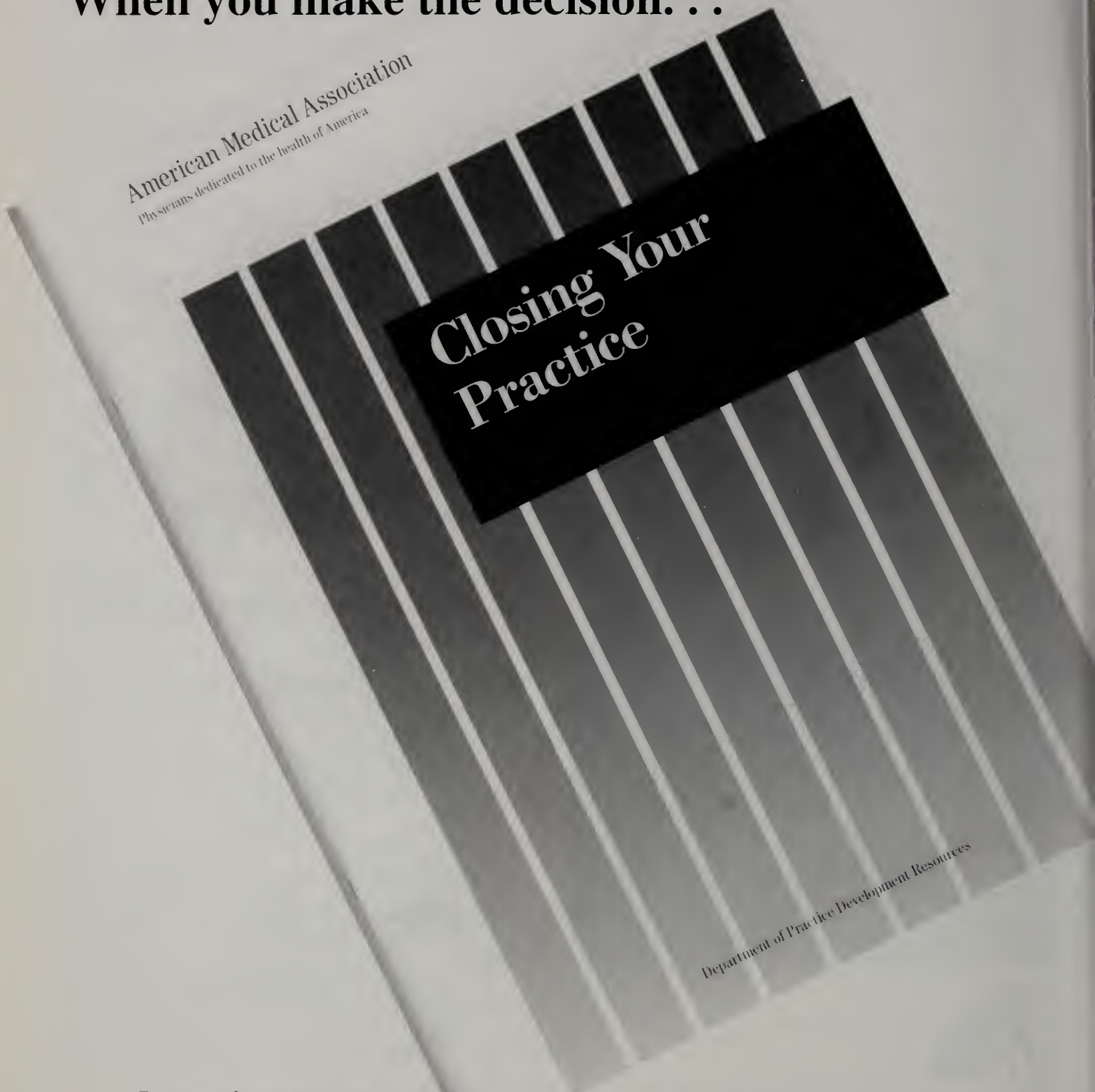
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Sandra L. Maloney
Executive Director
Colorado Medical Societey

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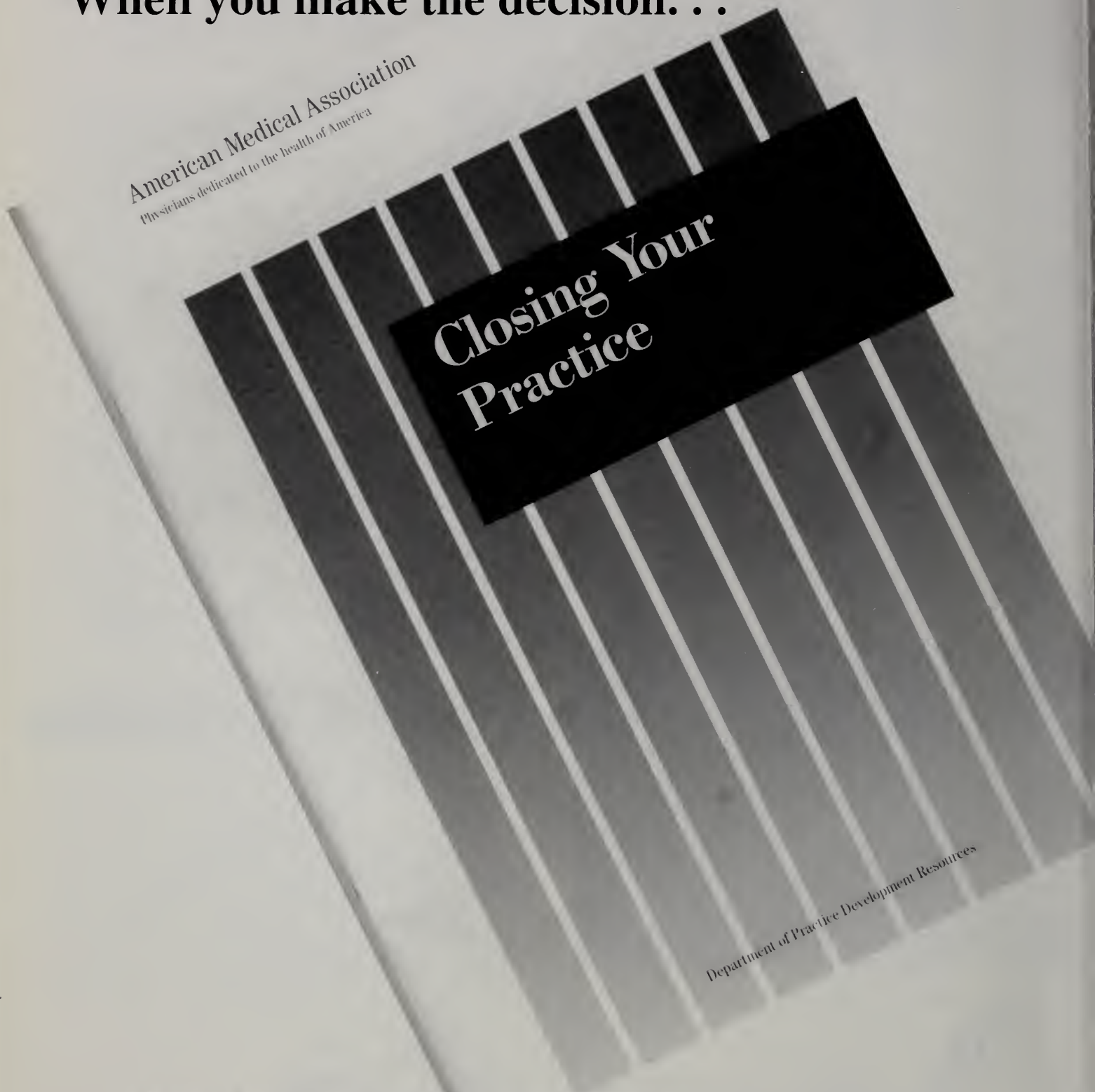
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Doctor, are you talking to parents about guns in the home?
Remember:
Separate guns and ammunition,
Lock up guns and ammunition separately,
Use trigger locks

If you keep a gun, empty it out, lock it up!

This message brought to you by the Colorado Medical Society,
Task Force on Youth

For more information call Suzi Shevell at 303-930-0407 or 1-800-654-5653

Domestic Violence:

How Physicians Can Help Children

This information was provided by B.B. Robbie Rossman, Ph.D



"It all depends on how you look at it" has been the theme of several recent articles concerning wife abuse. But, who does "look at it?" It is estimated that 3-10 million children are exposed to violence between their caregivers each year in this country (Strauss, 1991), with 34,000 children exposed in Colorado alone (Colorado Department of Public Health and Environment, 1994). Exposure is regarded as a form of psychological/emotional maltreatment that can be reported to Child Protective Services (APSAC, 1995). Exposure, how or what children witness, takes on different forms in different families, from watching a parent being killed, to being in the room where battering is ongoing and trying to intervene (thus risking injury), to hearing the conflict, to seeing the results as an injured parent or broken furniture, to experiencing the conflict in the fear, tension, and elaborate precautions of the battered spouse to avoid further violence. Exposure even occurs prenatally, with nearly 50% of abusive husbands battering their pregnant wives, resulting in four times the risk of low birth weight infants and a higher than expected level of birth defects (Chiles, 1988; U.S. Senate Hearings, 1990). Some of these spousal conflicts involve aggressive behaviors on the part of both spouses, but National Surveys have found that men are more likely to repeatedly beat their partner and women are more likely to suffer severe injury requiring medical attention (Morse, 1995). Women tend to fight back to protect themselves and their children. Even in studies of community violence exposure, family violence plays a role. Shahinfar (1997), working with children 3.5-4.5 years of age, found that 78% had been exposed to one violence incident of some type, and 41.9% of the children had been exposed to violence in the home.

Exposed children experience a number of reactions since they are **fearful for their own safety, the safety of loved ones, and are often confused, angry or sad in observing their caretakers injure each other**. Children wonder if they are next. They also wonder if physical and emotional threat and abuse are an integral part of relationships. **Exposure to family violence and child abuse are found retrospectively and prospectively to be more common among those who later perpetrate violence (Widom, 1992). Child abuse is more common in parentally violent families, estimated to occur from 40-60% of the time.** Both battered and battering spouses suffer from violence in their lives, which some of them became accustomed to as children. Spousal violence does not benefit anyone, but the children are often thought of as the silent victims because they have little control over parental fighting and are often expected to keep the "family secret".

Research to date has suggested that exposed children, on average, have greater behavioral, social, and school problems than non-exposed children and has also been shown to be associated with children's difficulties in thinking, reasoning, and accurate appraisal of social situations.

Follow-up of children exposed to spouse abuse has shown that problems still remained at one year, being somewhat abated when mothers had left the violent household. **Greater improvement still was noted when children and their mothers took part in home-based intervention programs**. This suggests that identifying battered mothers and their children and putting them in contact with intervention agencies and programs in the community is both useful and important.

Several factors have been associated with greater child resilience with regard to the violence they witness: **the presence of a safe and supportive adult in or outside the family**; the lack of physical or mental disability; lack of premature birth; higher family socioeconomic resources which usually means higher educational levels; and,

higher child intelligence. Most of these factors are difficult to modify, **but a professional's establishment of a positive, consistent relationship with a child may be of great help to that child in combating adversity.**

To the extent that we can assist children and battered mothers find community resources to help them, we are validating our investment in human well-being and our professional commitment to "do no harm", either by commission or omission. However, remember that some families may not know, feel, or be willing to admit that they are in danger and need help. On average it takes five attempts for a battered woman to leave a battering relationship. **The most common reason battered women give for finally being able to leave a violent relationship is fear for the safety of their children**. Thus, helping battered mothers understand the potential psychological as well as physical danger to their children **may provide one avenue of communication that makes sense to them and around which they can mobilize energy**.

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Physicians and Terminal Care

by Gerald D. Reilly, MD
Pueblo, Colorado

"There is an obvious fear of pain and of painful death driving a movement to subvert the role of healers..."

This paper presents my best effort to employ logic to assess solutions to a developing problem in medicine and society. It is an interesting coincidence that the Supreme Court just rendered its decision on physician-assisted suicide, which, of course, does not guarantee a right, but does not inhibit the right to be established in individual states.

As physicians, we rely heavily on logical thought processes to produce desired results, both research and clinical. Our work is meant ultimately to improve lives by improving function or relieving pain. In a philosophical sense, this is called beneficence; and it is an ethical goal for which we strive.

In the 1995 volume of *"Neurosurgical Topics"*, this problem was addressed and there was a quote from Emmanuel Kant that "a profession having a common knowledge, duty, and hopes has a philosophy." Socrates introduced the theory of knowledge with logic as a method of tackling moral and practical problems. Hippocrates at the same time articulated the first elements of a philosophy of medicine. The philosophy of medicine has historically employed logic to think about health and illness, ultimately resulting in the "scientific method" during the Renaissance Age, which has proven so valuable in medical advancement. Surgery came into being in an atmosphere of a maturing scientific philosophy which requires a purpose beneficial to mankind.

Now we see advanced technology, operating microscopes, image-guided surgery, and computer-assisted planning used for the betterment of man. And yet, the public seems to be in an uproar over the technological developments that seem to painfully prolong life. This in the philosophical sense would be a maleficence. It seems to occur when the application of technology is not tempered by logic and logical thinking.

To address just such issues, The Hastings Center was established in 1969 as a center for research in ethical issues in medicine. An article in the Hastings Report May 1995, explains the English principle of health care balancing individual autonomy with justice to society as a whole.

As our choices do not take place on a purely individual setting, autonomy must be seen in the context of society as a whole.

Marsha Angell, in a January *New England Journal* editorial, stated that the most important ethical principle in medicine is respect for each person's autonomy, or a right to choose, and that it should always take precedence. This view, of course, ignores completely the issue of unintended consequences. A clear example of maleficent results from a compassionate motivation lies in the current clamor to recognize a right to die. The very question results from a crisis of confusion and logical thinking. The question is illogical, death comes to all. There is no right to a natural and inevitable event. Our right lies in our expectation for compassionate care sufficient to allow a dignified death.

If a right to die is translated to mean the right of a patient to ask for physician-assisted suicide, feeling his quality of life is too low to live, we can see by application of simple observation and logical thought where this will inexorably lead. At present, the request is quite reasonably to allow physicians to assist a terminal patient having intolerable pain to commit suicide. If this becomes a legal right, the patient who is too impaired to self-administer will demand his right to physician-assisted suicide

The patient who is unable to self-administer a lethal agent has a

right under the Americans with Disabilities Act (ADA) to the same legal treatments as others. The ADA will see to it that a lethal agent be administered to a disabled person who cannot do it himself if this is a right others who can self-administer have. And for those whose quality of life is poor but cannot communicate, there are legal surrogates who can request or demand access to this right. How long before the law must recognize this right for those who are suffering but not terminal? By what constitutional rights do people with terminal illness who are going to die anyway have access to relief that is not available to others who have a lifetime of suffering ahead of them, such as patients with neurodegenerative disease? These patients with long term suffering have the same rights that short term sufferers have. Ultimately the law is modified to expand the new right as all rights have been historically expanded. In deference to autonomy, the rights to a physician-assisted suicide would have to be granted to every citizen who wants to claim his right, if it is found to be a constitutional right or state's right.

Logically thinking, this right will be applied based on the quality of life. Surrogates will then have the right on behalf of those who cannot communicate.

If one doubts that this could result in a maleficent situation for society as a whole, I would draw attention to world history, recent, past, and present: No less a star than Socrates himself was assisted in suicide with hemlock when his peers did not approve of his ideas. In the 1930s, Germany was a sophisticated society and a world leader medically. J. Lifton, in his book, *"The Nazi Doctors,"* reports how well-intentioned people with compassion for those dying in pain legitimated physician-assisted suicide. It was expanded to those who could not do it themselves and then to those who needed but could not ask. As the concept became more acceptable, the practice expanded to those whom the leaders deemed unhealthy for society. It became a big job, and doctors were recruited for their expertise, in the name of public health, to devise more efficient means to exterminate these threats to a healthful society. Doctors devised and operated the gas chamber. Lifton interviewed many Nazi doctors and reported his opinion that "They were not evil men doing evil things. They were ordinary men doing evil things".

Can we decide that assisted killing once considered wrong is now acceptable and morally right? Ethics by consensus would exonerate the Nazi doctors of World War II because their society did not disapprove at the time. The Nuremburg trials refuted such a concept. Mere legality was declared an unacceptable defense and the Nuremburg Code for Moral Caring was established. In *"Regulating Deaths"* by Doctor Carlos Gomez of the University of Virginia, it was revealed how, in recent times, the Dutch reintroduced euthanasia and assisted suicide into contemporary society. The current Dutch experience proves even today that the circle of permissible practice is extended in the name of quality of life so that there are widely reported cases of involuntary assisted deaths, not just in the terminally ill, but in the very young, the very old, and the unwanted, including the depressed.

In spite of these clear and historical examples of incipient corruption of individual autonomy and in the more egregious example of justice itself, our courts are trying to find a new right to assisted suicide which, if offered, would be the first constitutionally guaranteed health-care right guaranteed, before pain relief, psychiatric care, or even lifesaving surgery.

The Ninth Circuit Court in Washington has found a right to assisted suicide in a liberty interest, which the Second Circuit Court in New York specifically rejected, asserting that our national history and tradition reveal the opposite to be true. This court then asserted a right to physician-assisted suicide on a due process basis, inexplicably refusing to recognize the difference between administration of an agent designed to kill and the legitimate right to refuse treatment. This likewise ignores logically important distinctions historically upheld in both law and medicine. To help with our deliberations in this matter, The Hastings Center has completed a worldwide project involving 14 countries to examine the goals in medicine in light of contemporary problems and developments. The group concluded medicine should seek to define from within its own history, traditions, its own values and directions, rather than let society do it from the outside. A medicine that has no inner direction or core values will be too easily victimized and misused by society if it lacks the resources to resist encroachment upon it, as happened most notoriously with the Nazi and communist medicines. Medicine needs to have its own internal compass and abiding values which will be stronger if resting upon its traditional and largely universal goals. This group developing four goals that represent the core values of medicine.

- The prevention of disease and injury and the promotion and maintenance of health.
- Relief of pain and suffering caused by maladies.
- The cure and care of those with a malady and the care of those who cannot be cured.
- The avoidance of preventive death and the pursuit of a peaceful death.

Adherence to them will help medicine maintain its integrity in the face of political or social pressures to serve alien purposes. As you can see, depending on circumstance, there is a paradigm shift at work directing our attention to care over cure where advanced technology is not producing the desired better life. There is an obvious fear of pain and of painful death driving a movement to subvert the role of healers in the name of compassion. This is precisely where the Colorado Medical Society can provide a unique contribution, not only in patient care, but also in reaffirming the core

(Continued on following page)

Physicians and Terminal Care
(Continued)

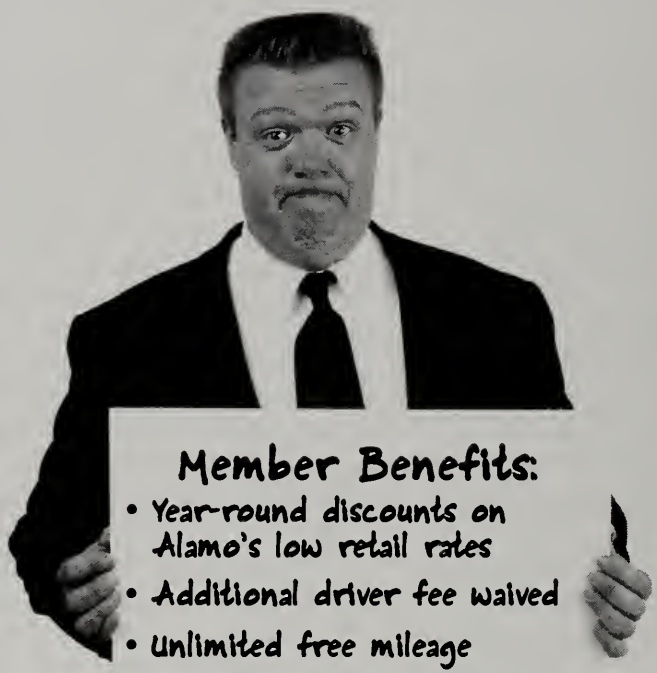
values of medicine. The relief of pain is among the most ancient duties of the physician and traditional goals of medicine. Contemporary medicine is not meeting that goal. Palliative care is an emerging field of great importance and needs the support of a specialty made up of logical thinkers with theoretical and technical expertise in pain relief and the stamina and will to see it through. There are great inadequacies in pain relief and the application of available knowledge and the medical and cultural support to make decent relief routinely available. When Kathleen Foley addressed this issue in the January *New England Journal of Medicine*, she identified three major factors in suffering, which are existential distress, described as the experience of life without meaning, psychological distress, and pain. Logical thinking would indicate that existential distress is not appropriately treated by a terminal intervention. Paul McHugh, Chairman of Psychiatry at Johns Hopkins, wrote in *The American Scholar* that demoralization of this type is a universally treatable mental condition. Hopeless doctors, however, ready to see patients as untreatable, produce hopeless patients and a zeal for terminating effort. He further states that patients inclined toward suicide, whether in pain or not, were suffering from depression and that actions to hasten the death of such persons are the ultimate neglect of patients with symptomatic depression and are really a form of collusion with insanity.

Pain, I would assert, deserves the full attention of the medical community to offer effective, rational, therapeutic intervention to enhance the quality of patients who are dying. Physicians have the capability of taking the lead in pain relief technology and application and education.

Medicine does not have to confuse compassion with competence in the case of terminally ill patients.

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Thoughts on homeopathy

Dear editor,

I would like to complement your article on Homeopathy printed in *Colorado Medicine* for August, 1997. It is refreshing to see an open minded approach to this form of treatment. In my medical community, I hear mostly ridicule of anything outside of mainstream medicine. Articles such as this educate physicians who are not aware that there is some legitimacy to certain alternative medical approaches. I hope you will be printing additional articles exploring other alternative treatment approaches.

Thank you.

Sincerely,

William H. Leyva, M.D.

Dear Sirs:

Thank you so much for the article, in the August issue of *Colorado Medicine*, on homeopathy, and for the explanation of the effectiveness of diluting drugs.

Having read it, now I'll know exactly what to do the next time I go to the Texaco station: the less gasoline I pump into my car, the more miles I can drive with it!

Of course.

Sincerely,

E.B. Liddle, M.D.

Helmets in soccer games

Dear sirs,

As a CMS physician and soccer parent, I have noted a trend towards a huge increase in popularity of youth soccer. I have also noted a trend towards increasing numbers of soccer related head injuries. It is amazing to me that a contact sport that is the only game I can think of in which players try to hit the ball with their head, does not involve any head protection.

It dawned on me that as a prominent neurosurgeon, Dr. VanderArk would be the perfect person to advocate this issue. I think the public is tired of hearing from medical groups strictly from the business pages, and it is time we start to take the moral high ground on some medical issues.

If you question the scope of this issue, I suggest you drive by the Cherry Creek soccer fields at Arapahoe and Parker roads on any Saturday, and see the thousands of people there. Just in one game yesterday, I witnessed the goalie on my sons team hit in the face by an extremely hard hit ball, and my son was tripped to the ground and kicked in the head by the surrounding players attempting to strike the ball. Luckily neither of these events resulted in more than headaches, but I have treated my sons best friend for two soccer related concussions. Perhaps this, and other similar issues, are ways we can move towards better public awareness of our organization, and what medicine is really all about.

Sincerely,

Christopher J. Verkler M.D.

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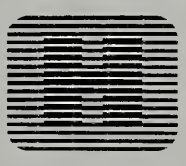
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Major shock wave rolls through physician membership listings of Northern and Central Colorado.

As is too often the case, we word mechanics have a misfire that can be likened to the science of "plate tectonics". (Many readers would hasten to add that "What we're talking about here is a major 'fault' in our communications abilities.)

When the misfire occurs it is accompanied by aftershocks that bubble up throughout the text or body of our message. That's what happened in the **1997 Medical Office Resource Book**: a shock wave in the computer page processing program.

We located the epicenter in Greeley somewhere between the **"B"** and the **"G"** in the alphabetical member listings. The first shock was recorded on Page 139.

There was another major quake in the program, and this occurred further south in Loveland, somewhere between the "S" listings of Loveland and traveled out, all the way to Monument, Colorado.

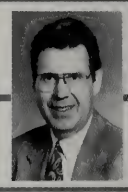
All of the listings between the "S" in Loveland and the "A" in Monument listings were wiped out, and this occurred, starting on Page 165.

"Damage Control" was summoned immediately following the first phone call from one of the missing physicians, who said "How come Montrose docs are not listed in the book?" The only thing "Damage Control" could do at that point was start picking up the pieces.

We've assembled the missing listings and the missing pages herein on the following pages. They are labeled **"Medical Office Resource Book Appendix I** and **Appendix II. THEY ARE PERFORATED,** so you can neatly remove them from this magazine and insert them in the appropriate places in the Resource Book. These instances are regrettable, but they do happen and we don't have sharp-enough eyes to catch the upheaval until the book is cut in stone.

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Colorado Physician Network, Inc.



Announcing "EPIC"

by David M. Martz, MD
President CPN

On September 9, CPN, RMHMO, COPIC, and Mountain Medical Affiliates (MMA) publicly announced the creation of "EPIC" , a consortium designed to provide a combination of services that will more effectively meet the needs of those whom we serve. The similarity of our basic core values make this a logical response to current trends.

The result of this consortium may include:

1. A dramatic increase in the number of "covered lives" (perhaps up to 450,000!), creating a much stronger "presence" in the marketplace;
2. The expansion of our panel to around 5,000 physicians, which will provide the degree of choice demanded by health care purchasers in this era;
3. The establishment of a multifaceted product line –HMO, EPO, PPO, and indemnity policies– capable of meeting virtually all of the needs of the health care market;
4. The implementation of integrated physician services –such as liability risk management with disease management guidelines, credentialing simplification, and unified office QA visits– to the practices we all serve in Colorado;
5. The sharing of data collection and analysis from hundreds of thousands of covered lives, generating vast resources of information;
6. Possible coordination of marketing efforts so we are working together rather than independently;
7. Potential streamlining of operational activities with greater efficiency and cost reduction.

The four organizations are not merging assets; there is no purchase or buy-out, but rather a commitment to coordinate our efforts on behalf of Colorado physicians and patients.

This opportunity will allow us to accelerate the fulfillment of our vision of the past two years. Now we are joined by others who share our dreams. The responsibility – and challenge– to "Make it Happen" is at hand at last! Join us now in this Bold Move for health care in Colorado!

Vest, David M, MD
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(H) 2015 Hawthorne Ave
Grand Junction, 81506 (970)242-7475
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Grand Junction, 81501
(H) 1319 N 16th St
Grand Junction, 81501
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FAMILY PRACTICE

Wheeler, Deborah A, MD
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Grand Junction, 81501 (970)243-7245
(H) 1930 S Broadway
Grand Junction, 81503 (970)245-2324
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(H) 2282 El Monte Ct
Grand Junction, 81503
MESA COUNTY MEDICAL SOCIETY
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OB & GYNECOLOGY

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(H) 1607 Fairacres Dr
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(H) 3725 W 20th St
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Greeley, 80631 (970)353-4322
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Greeley, 80631
(H) 1845 36th Ave Ct
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Greeley, 80631 (970)351-8020
(H) 7239 W Canberra
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1900 16th St
Greeley, 80631 (970)350-2427
WELD COUNTY MEDICAL SOCIETY
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HAND SURGERY

Blattner, Mary Austin, MD
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Greeley, 80631 (970)350-2434
(H) 1221 49th Ave
Greeley, 80634
WELD COUNTY MEDICAL SOCIETY
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Blattner, Robert Elliott, MD
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GENERAL PRACTICE
FAMILY PRACTICE

Simon, Frederick S, DO
222 S Nevada Ave
Montrose, 81401 (970)249-4745
(H) 62917 Peach Rd
Montrose, 81401
CURECANTI MEDICAL SOCIETY
FAMILY PRACTICE

Stangebye, Lars A, MD
816 S 5th St
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CURECANTI MEDICAL SOCIETY
FAMILY PRACTICE

Steidl, Lester J, MD
816 S 5th St
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CURECANTI MEDICAL SOCIETY
ANESTHESIOLOGY

Story, Paul G, MD
231 S Nevada Ave
Montrose, 81401 (970)249-1210
(H) 62062 Charolois Dr
Montrose, 81401 (970)249-7485
CURECANTI MEDICAL SOCIETY
OPHTHALMOLOGY

Thurston, Jon R, MD
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Montrose, 81401
CURECANTI MEDICAL SOCIETY
ANESTHESIOLOGY

Vader-Hammes, Mary, DO
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Montrose, 81401 (970)249-2421
(H) 68128 E Oak Grove
Montrose, 81401 (970)240-4708
CURECANTI MEDICAL SOCIETY
PEDIATRICS

VanGemert, Robert J, MD
164 Colorado Ave
Montrose, 81401 (970)249-6670
(H) 2754 E Miami Rd
Montrose, 81402 (970)249-6979
CURECANTI MEDICAL SOCIETY
FAMILY PRACTICE

Wiard, Thomas D, MD
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Montrose, 81401 (970)249-2421
CURECANTI MEDICAL SOCIETY
PEDIATRICS

Wiesner, Paul D, MD
231 S Nevada Ave
Montrose, 81401 (970)249-1210
(H) 61501 Lobo Dr
Montrose, 81401
CURECANTI MEDICAL SOCIETY
OPHTHALMOLOGY

Winkler, Louis H, MD
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(H) 61614 Hwy 90
Montrose, 81401 (970)249-8997
CURECANTI MEDICAL SOCIETY
ORTHOPEDIC SURGERY

MONUMENT

Davis, Ben K, MD
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Monument, 80132
EL PASO COUNTY MEDICAL SOCIETY
ANESTHESIOLOGY

Devalon, Melissa L, MD
1770 Deer Creek Rd
Monument, 80132 (719)488-2244
(H) 18958 Spyglass Cir
Monument, 80132
EL PASO COUNTY MEDICAL SOCIETY
FAMILY PRACTICE

Gibbs, Robert H, MD
1770 Deer Ck Rd
Monument, 80132
(H) 295 Jack Boot Way
Monument, 80132
EL PASO COUNTY MEDICAL SOCIETY
FAMILY PRACTICE
ADOLESCENT MEDICINE

Liester, Mitchell B, MD
PO Box 302, 236 N Washington St, # 5W
Monument, 80132-0302 (719)488-0024
(H) 625 Silver Saddle Rd
Monument, 80132
EL PASO COUNTY MEDICAL SOCIETY
PSYCHIATRY

Malowney, Robert C, MD (Ret)
(H) 19815 Indian Summer Ln
Monument, 80132 (719)481-8881
DENVER MEDICAL SOCIETY
THORACIC SURGERY
CARDIOVASCULAR SURGERY

Shahan, Patrick B, MD
550 Hwy 105
Monument, 80132 (719)488-9860
(H) 1210 Pleasant View Ln
Colorado Springs, 80921 (719)488-2031
EL PASO COUNTY MEDICAL SOCIETY
FAMILY PRACTICE

Winans, Robert E, DO
PO Box 1408
Monument, 80132 (719)596-5665
(H) 17585 Chipped Arrow Way
Monument, 80132
EL PASO COUNTY MEDICAL SOCIETY
GERIATRICS

MORRISON

Domurat, Michael F, MD
36 W Ranch Tr
Morrison, 80465
(H) 36 W Ranch Tr
Morrison, 80465
ARAPAHOE MEDICAL SOCIETY
ANESTHESIOLOGY

Edmundson, Arlo R, MD
6984 W Hwy 285
Morrison, 80465 (303)697-8549
(H) 6984 W Hwy 285
Morrison, 80465
ARAPAHOE MEDICAL SOCIETY
GENERAL SURGERY

Sullivan, Terrance J, MD
PO Box 1199
Morrison, 80465 (303)831-3259
DENVER MEDICAL SOCIETY
OCCUPATIONAL MEDICINE

NIWOT

Tseng, Jennifer S, MD
(H) 8427 Brittany Pl
Niwot, 80503
LARIMER COUNTY MEDICAL SOCIETY
FAMILY PRACTICE

NORTHGLENN

Phelps, Dwight S, MD
PO Box 33210
Northglenn, 80233
DENVER MEDICAL SOCIETY
EMERGENCY MEDICINE

UNIVERSITY OF MARYLAND, BALTIMORE

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If you're like most Bridge players, you're always hoping for good cards. Well, here's one solution: These cards are always good! CMS, in celebration of its 125th Anniversary, has produced these Bridge decks, excellent for gifts or for your personal use, printed with the Colorado Medical Society seal in gold on a red back, they are Bridge size plastic coated linen cards.

They're just $4.25 per deck including postage and handling. All proceeds go to the Colorado Medical Foundation, so this is one bridge hand that's a win-win-win situation. Order now!

You needn't be the "dummy" in this hand. Whether you play convention, tournament, Masters or social, you'll love these cards. Just mail the coupon below with your check. Supplies Are Limited! So Hurry!

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Mail to: P. O. Box 17550, Denver, CO 80217-0550 (Allow two weeks for delivery .

What About AIDS?

Information supplied by Patty Cook,
Health Education
Denver Museum of Natural History

Denver Museum of Natural History to host Exhibit on AIDS



Coming this fall, the Denver Museum of Natural History is preparing to host the first national traveling exhibition on AIDS.

What About AIDS? was developed by the National AIDS Exhibition Consortium in collaboration with the Centers for Disease Control and Prevention. The exhibition will premiere at the museum an Oct. 3rd and continue its run through Jan. 3rd.

This educational public health exhibition highlights the vital issues developed from this disease in a clear and concise professional format appropriate for children and adults. Visitors learn about current medical research on HIV and AIDS, including the history, definitions, and explanations of the disease.

The World Health Organization estimates that roughly 13 million people have been infected with HIV, and that by the year 2000, that number may triple. Scientists believe we are years or maybe even decades away from a cure.

To fight the disease, experts suggest that prevention through education is the only vaccine. This exhibit presents life saving information in a comfortable manner to children and their parents.

What About AIDS? is divided into five sections. Two introduction panels lead visitors into the exhibit. These panels allow visitors the chance to make a conscious decision whether or not to enter the exhibit.

"What is HIV and AIDS?" details scientific information about the virus that causes AIDS. The Kids Area" delivers appropriate information on the disease to children between the ages of 5 and 10.

"Protect Yourself" gives information on how the virus is spread and how to protect yourself. The last section, "What Else Can We Do?" showcases how communities and scientists around the world are responding to the epidemic, and are searching for a cure. There is also a personal "Memorial Book" in this section where visitors can write a message or the names of those they care about who have died from complications related to AIDS.

The arrival of the exhibit in Denver will be timely, taking place during both AIDS Awareness Month (October) and World AIDS Day (December 1).

To ensure maximum community involvement the museum has collaborated with Colorado AIDS Project and AIDS Coalition For Education, a powerful group of educators in Colorado. During the run of the exhibit the museum will offer educational programming to general museum admissions through several presentations of the play "Secrets" and a free day to all Colorado residents on World AIDS Day,

For more information please call the Denver Museum of Natural History at 303/322-7009.

COLORADO MEDICAL SOCIETY ANNUAL 1997 MEETING

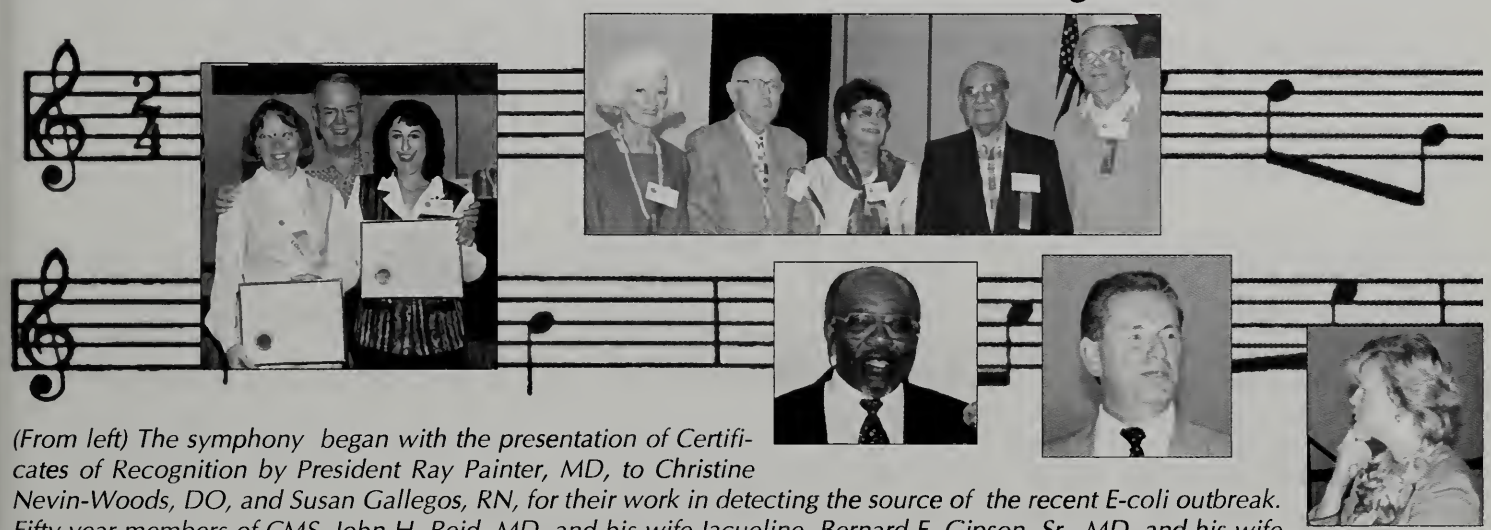
Proceedings of the House of Delegates

at their

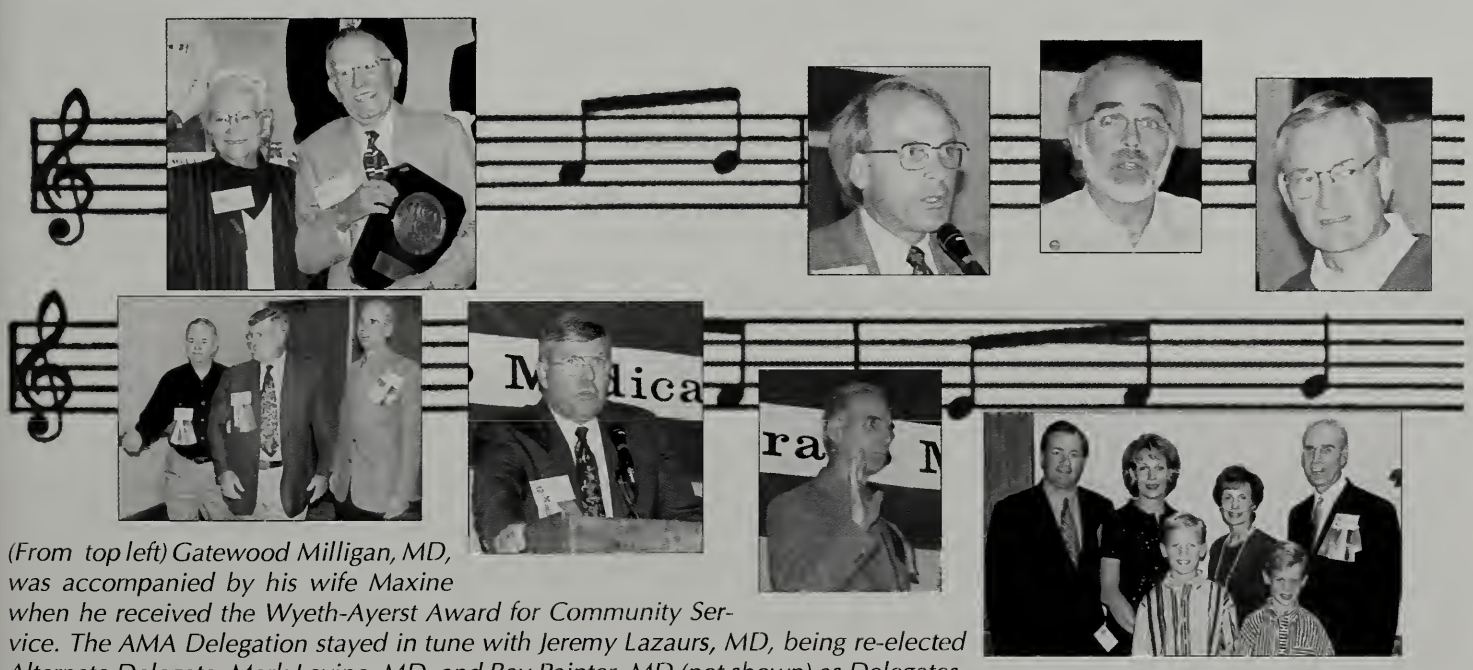
127th Annual Meeting

September 12 - 14, 1997

Snowmass Conference Center, Snowmass Village, Colorado



(From left) The symphony began with the presentation of Certificates of Recognition by President Ray Painter, MD, to Christine Nevin-Woods, DO, and Susan Gallegos, RN, for their work in detecting the source of the recent E-coli outbreak. Fifty year members of CMS, John H. Reid, MD, and his wife Jacueline, Bernard F. Gipson, Sr., MD, and his wife Ernestine, and Robert R. Oden, MD, were honored. John Perkins began Saturday's activities on the right note at the Prayer Breakfast with an inspiring discussion about community, while all eyes were fixed on Joe Bujak, MD, and Linde Howell as they orchestrated an engaging educational program to explore the changing dynamics of health care.



(From top left) Gatewood Milligan, MD, was accompanied by his wife Maxine when he received the Wyeth-Ayerst Award for Community Service. The AMA Delegation stayed in tune with Jeremy Lazaurs, MD, being re-elected Alternate Delegate, Mark Levine, MD, and Ray Painter, MD (not shown) as Delegates, and scored a new face in Steve Thorson, MD, as Alternate Delegate. (Bottom left) Drs. Painter and VanderArk conduct the new CMS President-elect George Shanks, MD, (middle) to the podium. After taking the oath of office to become the 1997-98 CMS President, Dr. VanderArk and his family were a picture of harmony. Dr. VanderArk and his wife Phyllis (far right) were joined by their daughter Jill, her husband Michael Kalkman and their sons Alex and Cameron.

Proceedings of the House of Delegates — Annual Meeting 1997

The Colorado Medical Society House of Delegates met at the Snowmass Resort, Snowmass, Colorado, September 12 - 14, 1997 and took the following actions:

REFERENCE COMMITTEE ON BOARD OF DIRECTORS/CONSTITUTION & BYLAWS

Referred a Resolution to study representation in the Colorado Medical Society House of Delegates.
Adopted a Resolution to create a task force to address the criminal prosecution for outcomes of medical practice.
Adopted a Resolution to create an International Medical Graduate Section with voting representation in the Colorado Medical Society House of Delegates.
Adopted a Resolution to amend the Colorado Medical Society Policy on Ethics of Euthanasia. The amendment added language regarding physician assisted suicide.
Adopted a Resolution to work with the Colorado State Board of Medical Examiners to waive the fee for renewal of medical license for retired physicians who provide volunteer services.
Adopted a Resolution to allow the Colorado Physician Network (CPN) to use the phrase "created by the Colorado Medical Society" in conjunction with the CPN logo.
Adopted a Resolution to ratify a motion of the Board of Directors regarding the Colorado Medical Society support of the Mesa IPA in the law suit filed against the IPA by the Federal Trade Commission.
Accepted for filing:

Progress Report - AMA Delegation
Progress Report - Board of Directors
Progress Report - Council on Ethical & Judicial Affairs
Progress Report - Executive Director
Progress Report - CMS Education & Research Foundation
Progress Report - Organizational Study Committee

REFERENCE COMMITTEE ON HEALTH AFFAIRS

Adopted a Resolution to ratify a Motion of the Board accepting the recommendations of the Managed Care Task Force to not pursue legislation on senior formularies.
Adopted a Resolution stating that the Colorado Medical Society reaffirm its position on "hold harmless" clauses in physician contracts with managed care companies, and to support legislation or state government regulation to effect the following changes: 1) establish written policies and procedures regarding the rights of policyholders, 2) include a statement regarding methods of physician compensation, 3) establish a procedure to protect the interest of physicians from arbitrary or capricious termination without cause, and 5) request that the Colorado Division of Insurance review any utilization review requirement such as prior authorization, etc., for a denial rate.

(Continued next page)

Adopted a Resolution calling for the Colorado Medical Society to work toward less restrictive formularies, and requesting that CMS develop a model formulary, work with managed care industry to develop a uniform state-wide prior authorization and appeal process for non-formulary medications, and promote and support the concept that senior plan formularies for licensed Colorado insurance companies cannot be more restrictive than the least restrictive commercial plan marketed by that company.

Adopted a Resolution stating that the Colorado Medical Society assure that CMS members and components with expertise in credentialing be involved in discussions and negotiations relating to the credentials verification segment of the American Medical Accreditation Program (AMAP).

Adopted a Resolution to sunset Res-1-P, AM '91: Joint Sponsorship Policy.

Adopted a Resolution to adopt the American Medical Association recommendations on the ethical implications of capitation, which states 1) that physicians are obligated to evaluate a health plan's capitation payments prior to contracting with that plan, 2) physicians must not assume inordinate levels of financial risk, and should therefore consider a number of factors when deciding whether or not to sign a provider agreement, 3) stop-loss plans should be in effect to prevent the potential of catastrophic expenses from influencing physician behavior, and 4) physicians must be prepared to discuss with patients any financial arrangements which could impact patient care.

Accepted for filing:

Progress Report - Council on Legislation
Progress Report - COMPAC
Progress Report - Health Affairs Counci

HIGHLIGHTS OF BOARD OF DIRECTORS MEETING — September 11, 1997

Copic: The Board was reminded that they had previously endorsed the concept of studying the malpractice system to determine if a no-fault system might be a better way to go. They were also reminded Copic had received grant monies from the Robert Wood Johnson Foundation to conduct such a study. Dr. Mason Howard played an integral role in the study. Dr. Jerry Buckley then gave a presentation on the subject of possible reform of the current medical liability system, and explained the reason why changes in the current system and related legislation would not be pursued. The outcome of the studies are still confidential and therefore, not available for publication or distribution. If specific details are needed, Dr. Buckley asked Board members to contact him directly.

CMSA: Ms. Stella Shanks stated that the Alliance is celebrating their 75th birthday this month. The Alliance consists of nine counties, with a slight increase in both local and national membership. They will be conducting a fund raiser for the AMA Education and Research Foundation during the CMS Annual Meeting. Ms. Shanks thanked Dr. Painter, Dr. VanderArk, the CMS Board and staff for all of their support over the past year.

AMA Delegation: Dr. Quinn presented the report. He stated that the AMA Board of Trustees, along with members of the councils, attended a retreat last week. Discussion took place regarding physician specific information. Colorado is ahead of the curve in this regard. The AMA will be conducting a major conference this Spring regarding the ethical issues surrounding genetics and genetic testing. Dr. Quinn feels that state societies may not be happy with some of the initiatives involved in the AMA's upcoming, major membership drive. Dr. Karlin stated that he planned to run for the AMA Board of Trustees in the near future. Dr. VanderArk stated that he has been asked by the AMA to be in charge of their Educational Program at the Interim Meeting in Dallas, Texas. He will be putting together two ninety minute sessions on accountability and outcomes.

Colorado Physicians Network (CPN): Dr. Martz stated that enrollment in Rocky Mountain Physicians Choice at the end of August was approximately 2,300 lives. Dr. Martz then explained the guidelines used to market their product. Dr. Martz explained that a new physician governed organization called Equal Partners In Care (EPIC) has been created. Four physician organizations, Copic, CPN, Mountain Medical Affiliates, and Rocky Mountain HMO, are part of this new limited liability company (LLC). The database of EPIC will contain information to help physicians determine whether they need to adopt new, or modify current, practices for the treatment they provide.

Next Meeting will be held November 21, 1997 at the Colorado Medical Society offices.

COLORADO MEDICAL SOCIETY

Delegate Attendance

127th Annual Meeting
September 12-14, 1997

Arapahoe
Raul Alvarez, MD
Roy M Bartee II, MD
Deborah K Bublitz, MD
Richard B Capek Jr, MD
James R DeLine, MD
Joseph Y Dwoskin, MD
Sheri L Gipson, MD
Steven J Gulevich, MD
Merl M Jacobsen, DO
Susan L Jolly, MD
David M Knize, MD
Allan B Kortz, MD
Joseph L Kovarik, MD
Lee E Krauth, MD
Mark A Levine, MD
Cynthia L Martin, MD
Howard L McCarthy, MD
Bernard J Powers, MD
Richard H Stienmier, MD
Leigh Truitt, MD
Walter B Vernon, MD
Valerie M Wassill, MD
John Q Gallagher, MD

Aurora-Adams County
Roderic D Gottula, MD
Leon S Greos, MD
Angeline D Heaton, MD
Carl E Heaton, MD
Renu Jalota, MD
Miguel A Morales, MD
Ruth B Nauts, MD
Robert A O'Dell, MD
M Eugene Sherman, MD
Harry S Spaulding Jr, MD
Christopher J Unrein, DO
James P Wilson, MD
Jan F Baumgardner, MD

Boulder County
Alan E Benson, MD
Alfred N Carr, MD
Mary E Faini, MD
Scott L Replogle, MD
Gerald R Rupp, MD
Harry L Wherry, MD
William J Williams, MD
Lorraine E Wood, MD
Vernon E Zurick, MD
Richard L Brundige, MD

Clear Creek Valley
Chester M Cedars, MD
Richard S Cohen, MD
Wyley E Eaton, MD
Gordon Fleischaker Jr, MD
Thomas M Golbert, MD
Mark B Johnson, MD
Joel M Karlin, MD
Jan M Kief, MD
Nelson I Mozia, MD
Howard E Netz, MD
Walter Oppenheim, MD
Lynn Parry, MD
Dean L Sadler, MD
Kathleen Y Sawada, MD
Ronald E Tegtmeier, MD
M Robert Yakely, MD

Colorado Academy of Family Physicians
Patrick W Page, MD

Colorado Chapter of the American College of Emergency Physicians
Carla E Murphy, DO

Colorado Chapter of the American College of Surgeons
William G Rainer Jr, MD

Colorado Chapter of American Medical Directors
William A Solomon, MD

Colorado Gynecological & Obstetrical Society
Debra S Ganter, MD

Colorado Psychiatric Society
Kenneth D Krause, MD

Curecanti
Lynwood M Hopple, MD

Denver
Richard Allen, MD
Susan K Babcock, MD
Richard F Bakemeier, MD
Hirsh E Barmatz, MD
David N Campbell, MD
Glenn T Foust III, MD
Frederick L Grover, MD
David E Hutchison, MD
Alexander Jacobs, MD
Eugene D Jacobson, MD
David L Kelble, MD
Jeannie J Kinzie, MD
Paula H Koeller, MD
Charles E Koftan, MD
John L Lightburn, MD
Frank J Major, MD
Bonnie McCafferty, MD
Robert D McCartney, MD
Paul K Miller, MD
H Andrew Motz III, MD
Michael Muftic, MD
Nancy E Nelson, MD
James R Regan, MD
Edward A Rhodes, MD
Carol M Rumack, MD
Robert B Sawyer, MD
Janet E Schemmel, MD
Del Stigler, MD
Terrance J Sullivan, MD
Kathleen K Traylor, MD
Louise Converse Walker, MD
Jerome D Wiedel, MD

El Paso County
Francis J Barry, MD
J Richard Brusenhan, MD
Norman G Cole Jr, MD
Lewis A Crawford, MD
William E Emeis, MD
Fred M Feinsod, MD
Edward M Fitzgerald, MD
John H Genrich, MD
David C Martz, MD
Larry A Moore, MD
John B Muth, MD
Robert T Pero, MD
Joseph S Pollard Jr, MD
A Thomen Reece, MD
John L Sherman, MD
James J Simerville, MD
Duane R Spaulding, MD
Teresa H Struck, MD
Paul M Wall, MD

Fremont County
Peter J Gamache, MD
Robert D McCurry, DO

Intermountain
Jonathan C Feeney, MD

Larimer County
Thomas J Allen, MD
Bruce R Belleville, MD
Cory D Carroll, MD
Edward J Donner, MD
Robert Marschke Jr, MD
Krishna C Murthy, MD
Floyd V Stephens Jr, MD
Robert J Stuart, MD
Robert J Tello, MD
Steven J Thorson, MD
P K Vedanthan, MD
Deborah Weiskittel, MD

Las Animas County
Douglas McFarland, MD

Medical Student Component
Ryan A Aukerman
Robert A Brockmann
Daniel A Langer

Mesa County
Lee B Golter, MD
Robert S Hanna, MD
Paul B Jones, MD
Bronwen J Magraw, MD
Donald E Maier, MD
Richard A Moore, MD
Frederic Walker IV, MD
Jacob Webel, MD

Morgan County
Richard K Clise, MD

Mt. Sopris County
Ronal B Mason, MD

Northeast Colorado
Joseph Bonelli, MD, PhD
Patricia J Johnson, MD

Otero County
James M Satt, MD

Pueblo County
Robert L Drake, MD
Thomas K Gaide, MD
Muryl L Laman, MD
Richard Lawrence, MD
Alethia E Morgan, MD
Christine R Nevin-Woods, DO
Gerald D Reilly, MD
Robert E Tonsing, MD
William P Wilz, MD

Resident Physician Section
Brian L Johnson, MD

San Luis Valley
Raymond M Culp, MD
Michael G Firth, MD

Weld County
Thomas J Flower, DO

Women In Medicine Section
Sarah B VanScoy, MD

Council & Committee Appointments

Following are the appointments by CMS President Dr. Gary VanderArk to the Councils and Committees for the 1997-1998 CMS Program Year.

Long Range Planning Committee
- Barbara Reed, MD, Chair
- Brad Darley
- John Farrington, MD
- Gene Jacobson, MD
- Roderic Gottula, MD
- Allan Kortz, MD
- Muryl Laman, MD
- Louise McDonald, MD
- Ray Painter, MD
- David West, MD
- Medical Student Component Repr.

Organizational Study Committee
- John Farrington, MD, Chair
- Jack Cletcher, MD
- Jon Feeney, MD
- Jerry Hanson, MD
- Rich Quinn, MD
- Leigh Truitt, MD

Health System Reform Task Force
- Tom Allen, MD, Chair
- Linda Acosta, MD
- Richard Brownrigg, MD
- Richard Cohen, MD
- Angeline Heaton, MD
- Jeannie Kinzie, MD
- Jerry Kopelman, MD
- Muryl Laman, MD
- Sherri Laubach, MD
- Mark Levine, MD
- Louise McDonald, MD
- Nelson Mozia, MD
- Hugh Rohrer, MD
- Tom Schossau, MD
- Grant Steffen, MD
- Louise D Converse Walker, MD
- David West, MD
- Richard Wright, MD

Health Affairs Council
- Ned Calonge, MD, Chair
- Richard Brownrigg, MD
- Allan Kortz, MD
- Joel Levine, MD
- Peter Schaiberger, MD
- Paul Visconti, MD
- Mark Wallace, MD

Council on Legislatlon
- Chris Unrein, DO, Chair
- Tom Allen, MD
- Al Carr, MD
- Ben Galloway, MD
- David Hutchison, MD
- Mary Jo Jacobs, MD
- Brian Johnson, MD
- Joel Karlin, MD
- Larry Kipe, MD
- Pam Laman, CMSA
- Jeremy Lazarus, MD
- Lee Morgan, MD
- Stella Shanks, CMSA
- Daniel Thatcher, MD

Workers' Compensation and Personal lnjury Committee
- John Hughes, MD, Chair
- Tashoff Bernton, MD
- David Greenberg, MD
- Douglas Hemler, MD
- Alan Lipkin, MD
- Brent Lovejoy, DO
- Tom Morgan, MD
- Kathryn Mueller, MD
- Lynn Parry, MD
- Charles Schaap, DO
- Karl Stecher, MD
- Richard Stieg, MD
- Dennis Waite, MD

CMS/CHMOA Joint Committee
- Gary VanderArk, Co-Chair
- New President-elect of CMS
- Joel Karlin, MD
- Ray Painter, MD
- Richard Schaler, MD
- Gene Sherman, MD

Managed Care Task Force
- Gene Sherman, MD, Chair
- Bill Doig, MD
- Dave Hutchison, MD
- Mary Jo Jacobs, MD
- Joel Karlin, MD
- Kelly Lennon, MD
- Mark Levine, MD
- Pat Sillix, DO
- R. Douglas Yajko, MD

Data Committee
*Change Name to
"Accountability Committee"
- Nick Alsever, MD, Co-chair
- Dennis Waite, MD, Co-chair
- Ned Calonge, MD
- Tom Dunn, MD
- Richard Loeffler, MD
- Bonnie McCafferty, MD
- Tom Reece, MD
- Tom Reiley, MD
- Jim Simerville, MD

Committee on Professional Education and Accreditation
- Roy Stahlgren, MD, Chair
- Dick Bakemeier, MD
- Joe Bonelli, MD
- Shannon Burke, MD
- Rod Gottula, MD
- Ted Lewis, MD
- W. Gerald Rainer, MD

Medical lnformatics Committee
- Mike Victoroff, Chair
- Shannon Burke, MD
- Joe Dwoskin, MD
- Claude Poliakoff, MD
- Alfred Purdon, MD
- Rich Quinn, MD
- Dennis Waite, MD

Youth Task Force
- Mark Johnson, MD, Chair
- Patti Brown, CMSA
- Don Cook, MD
- Jim Delaney, MD
- John Genrich, MD
- Arlene Kellman, DO
- Rich Quinn, MD
- Jim Shira, MD
- Lawrence Wolk, MD

Patient Advisory Committee
Recommend that this committee be sunset and reestablished as a task force when a need arises.



John L. Lightburn, MD
Historian
Colorado Medical Society

"A little old lady with a nice smile"

Florence Sabin, MD

November 9, 1871-October 3, 1953

Anticipating the end of World War II, Governor John Vivian announced the formation of a Post War Planning Committee, naming subcommittees on industrial expansion, labor, tourist travel, banking, mining and others. But he made no mention of health. At the press conference, *Denver Post* reporter Frances Wayne asked whom he had in mind for health. "Just whom would you suggest?" he asked and she replied, "Florence Sabin."

He had not heard of her and asked around among his political friends. "What was she like? Would she be accepted by the conservatives?" "Oh, she won't give you any trouble," they replied. "She has spent all her life in the laboratory She knows nothing about medicine outside the cloister of the laboratory. She's a nice little, old lady with her hair in a bun and a nice, friendly smile. You might even like her, everyone else does." Reassured, he appointed her chair of the subcommittee on health. To appreciate the significance of Governor Vivian's appointment we need to go back in time about sixty-five years.

Florence Sabin was born on November 9, 1871 in a small frame house on Pat Casey Road in Central City. Her father, George Kimball Sabin had come to Central City in 1860 from Vermont and married her mother, Serena Miner in Black Hawk in 1868. Their first child, Mary, was born in 1869. In 1875, George moved his family to Denver where he could more easily look after his mining interests throughout the state. Their first Denver home was on Court Place between 15th and 16th Streets. In 1876, a baby brother was born and the girls were pleased to have a brother to play with. With a larger family, George Sabin found a larger home on Grant Street between 17th and 18th Avenues. It had a large enough yard to keep a cow and was a wonderful new home. The sisters could walk to school through the vacant lots enjoying the wild flowers on the way. But in February the baby brother died. On October 31, 1878, another baby brother was born, a source of great joy until it became apparent that their mother was not recovering from the birth. She died on November 9, ten days after delivery and Florence's seventh birthday. What sadness and grief those two little girls had to endure!

George was devastated by this loss and was unable to care for his two daughters. The two girls were placed temporarily in Wolfe Hall, an Episcopalian boarding school directed by Bishop Spalding. They stayed with the Spalding family until the summer when their father took them up to his small home in Leadville. At the end of the summer, George's brother, Albert, took them home to live with his family in Chicago.

Uncle Albert was a teacher with a loving and happy family, and provided an ideal home for the two Sabin sisters for the next four years. Albert gave to Mary and Florence a love of music, literature, nature and people. And most importantly, he gave them both an empathic understanding and unconditional love they had lost when their mother died.

One summer he took Mary and Florence back to the old Sabin Farm in Vermont where Florence learned to love her grandparents and also learned about the Sabin family and the patriarch, William Sabin, a Huguenot who fled religious persecution in France and came to the new world in 1643. He had twenty children and his son Levy was the first doctor in the Sabin family. George, Florence's father, would have made a good doctor, but he got the "gold fever," said Grandmother. She said, "It's too bad you aren't a boy, you would make a good doctor!" Grandmother died in 1884 and Florence could not return to the Sabin farm. Mary and Florence were then enrolled in the Vermont Academy, a college preparatory school where both were outstanding students trained to be hard working, self-reliant and avoiding frivolity with the strong traditions of Vermont. Here Florence had a strong interest in music as a career. The young women were not encouraged to go into science, but that changed as soon as she entered Smith College.

At Smith College, music took a back seat to a renewed interest in the sciences. Florence felt very much alone and isolated at both Vermont and Smith and relied heavily on Mary, who was two years ahead of her. She was painfully shy, saw herself as plain and unattractive and had no close friends. If you got close to someone, they died. So she immersed herself in her studies and achieved an outstanding academic record.

Dr. Grace Preston, the Smith College physician, took a special interest in young Florence and frequently encouraged her to consider going into medicine. She told her that it was hard being a pioneer, but it was worth it. She talked about Elisabeth Blackwell who was the first women to become a physician and had shown the way to other women. With such encouraging words, she went home for the summer at the end of her junior year eager to tell her father of her plans to go to Johns Hopkins. Her father greeted the news with silence, and Mary explained that the mining business had fallen on hard times and there was no money to send her to Johns Hopkins and she must be content to be a schoolteacher. Well she was not content, but school teaching became a temporary alternative while she earned enough money to go to medical school on her own. She was determined to be a doctor.

After receiving her B.S. degree in 1893, she returned to Denver where she taught at Wolfe Hall for two years. After two years of teaching she was invited back to Smith as an instructor, and in one year she had enough money for medical school. She received a scholarship to the Marine Biology Laboratory at Woods Hole for the summer and started her medical education at Johns Hopkins in the fall of 1896, three years after the medical school had opened.

The four years as a medical student were glorious years for Florence. Though taunted by her male contemporaries as a "hen medic", she directed her attention toward anatomy, physiology, chemistry, and the other basic sciences. Dr. Franklin P. Mall, the stern, Germanic professor of anatomy, impressed Florence with his passionate interest in research. He watched her carefully as she worked in the laboratory and was impressed with her meticulous work and devotion to a job well done. Indeed, he may also have been impressed with the shy smile and quiet demeanor of that petite woman who still looked like a school girl. As she completed the required work in anatomy, he gave her a research project on the structure and origin of the lymphatic system. She was delighted. This beginning research resulted in her first published paper while still a sophomore medical student She sent a copy of the paper to her father in Denver, telling him that this was all she had to offer him for the moment but she hoped to be sending more. That hope was never realized, because George Sabin died in December of that year. Now she could never make the home she had always planned for him.

Returning to school from the funeral, she spent most of her spare time working in Dr. Mall's laboratory and still doing well in her required studies. The slightest indication that he liked her work was all she needed to continue working for him. Indeed, he had become a surrogate father. She could do for him what she had never been able to do for her father.



Florence Rena Sabin, MD
(Circa 1939)

At the beginning of her junior year, she donned a long white lab coat with a stethoscope in her pocket to begin her clinical work in the hospital. She enjoyed her rotation in medicine, especially the weekly conferences at the home of Dr. William Osler. But she found the rotations through surgery and obstetrics stressful, especially the home deliveries. The quiet and peace of the research lab was much to her liking. So after receiving her MD degree and serving her internship at Johns Hopkins Hospital she was awarded a graduate fellowship in anatomy. She did such outstanding work that a reluctant board of trustees could no longer deny her, a women, a faculty appointment. As an Assistant in the Anatomy Department, she continued her work on the lymphatic system, which resulted in thirteen publications. She brought them all together in a monograph in 1913. Her teaching and laboratory work was rewarded in 1905 with her elevation to Associate Professor of Anatomy, and to Professor of Histology in 1917, the same year that Dr. Mall died. She was selected to write a biography of her mentor, Dr. Mall. The book turned out to be the story of the progress of medical education during his lifetime. Her energy seemed boundless, teaching, working in the laboratory, writing papers and books and supporting the efforts of Susan B. Anthony to win women the right to vote.

In the laboratory, her focus changed from cellular morphology to the dynamic process of cellular change that occurs, for example, when the body responds to tubercular infection. Her basic cellular studies which led to a better understanding of the mobilization of the body's defenses against infection attracted the attention of Dr. Simon Flexner, Director of the Rockefeller Institute of Medical Research. He came to Baltimore to see her and persuade her to leave Hopkins and come to New York to work with him as a member of the Institute. Dr. Sabin finally agreed and sadly left Baltimore and her beloved Hopkins in 1925. She had loved Baltimore and Johns Hopkins, but New York and the Rockefeller Institute, with its

(Continued next page)

large gray stone building overlooking the East River, were new and exciting. Flexner had planned a research program in which both he and Florence would collaborate. In the thirteen years she was there, she collaborated with eleven different eminent scientists. During this time, she received fourteen Honorary Sc. D. Degrees, numerous awards and memberships on many boards and committees. Retiring in 1938, she returned to Denver to make a home for her sister Mary. Those first years of retirement were busy with frequent trips back to New York, Baltimore or Washington, D.C.. Unfinished research projects needed her attention; committees and boards needed her wisdom. But the challenge handed to her by Governor Vivian soon occupied most of her time. After receiving pledges of support and advice from people like Ward Darley, dean of the University of Colorado Medical School, she first arranged for Dr. Carl Buck of the American Public Health Association to conduct a survey of the health needs of the state. When Dr. Buck submitted his report, she had 1,000 copies made so that the report did not end up buried in some desk drawer. She assembled a committee of almost 100 members representing all parts of the state and all factions and interest groups. She wisely kept the Governor informed and asked for his permission as she set about to accomplish the task of dealing with the deficiencies pointed out in the Buck Report. She quietly but effectively enlisted the support of the medical community. She identified those who would find the new health plan offensive, such as the state Civil Service Commission and the dairy industry and invited them to be on her committee. In 1945, a health bill had been introduced in the legislature, but it had been emasculated by amendments and had to be withdrawn. Knowing she had a battle on her hands, she set about to stump the state armed with leaflets and a determination to educate the people about the health bills. There were eight bills in all, and together they were known as the Sabin Health Bills. She traveled the state and testified before legislative committees. If she was at times frightened by the immensity of the task she had undertaken, she did not show it. She had picked the best committee she knew how to get and had chosen from it a competent executive committee and relied on their advice for presenting the matter of health to the legislature. She also listened to the advice of Drs. Roy Cleere and Ward Dafley. Of the eight bills, the Health Department Reorganization Bill was the most important and passed the legislature first. It was Dr. Sabin's greatest victory and she was present when Governor Knous signed the bill. Five other bills followed and two were defeated. It was a victory for her and a victory for the state. At 77 years of age, this little women accomplished more than many younger and stronger persons had been able to do; she had taken health out of politics. In the following two years, she did the same for Denver with the collaboration of Mayor Quigg Newton.

In writing about Dr. Sabin's retirement from the Rockefeller Institute, Dr. Lawrence Kubie wrote, "It was all done so unself-consciously and with such enthusiasm... Nothing could have represented more succinctly her unique qualities of enthusiastic and selfless yet passionate dedication to science as a way of life and as a nondeistic religion of the spirit."

The primary source for the information in this article was: *Florence Sabin, Colorado Woman of the Century,* by Elinor Bluemel.

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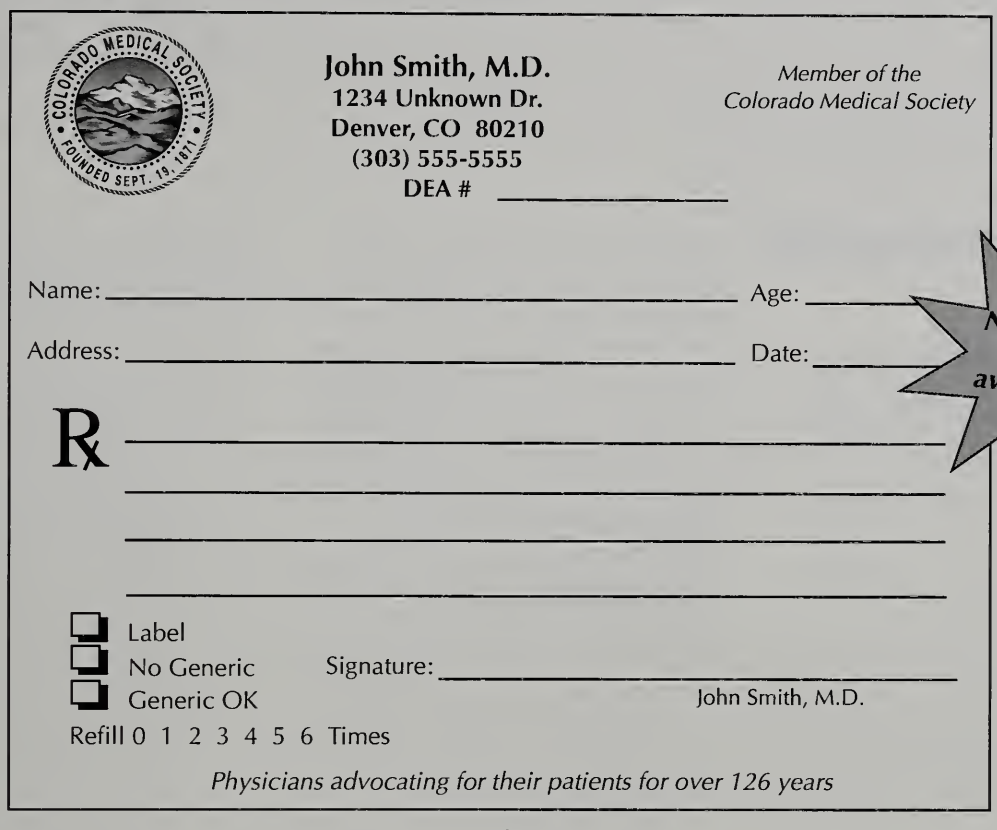
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Documentation Guidelines for the new single system examination

by Grant Steffen, M.D.
Medicare Medical Director for Colorado

"These new guidelines will affect all physicians, not just specialists."

The 1992 CPT contained the new Evaluation and Management (E&M) codes and their descriptions. Included in the description of a comprehensive examination was (and is) the phrase, "a general multi-system examination *or a complete examination of a single organ system*" (emphasis added).

The obvious question was, "What is a complete single system exam?" After five years of work, the American Medical Association (AMA) and the Health Care Financing Administration (HCFA) in conjunction with several specialty societies have defined this phrase and have released the new Documentation Guidelines that describe, for ten "organ systems," the documentation required to justify a *problem focused*, an *expanded problem focused*, a *detailed*, and a *comprehensive* single system examination. The ten organ systems are: cardiovascular, ear/nose/throat, eye, genitourinary, hematologic/lymphatic/immunologic, musculoskeletal, neurologic, psychiatric, respiratory and skin.

The AMA and HCFA have said the education needed for the proper use of these new guidelines is the responsibility of the specialty societies. However, recognizing the fact that not all physicians belong to specialty societies, and that all of these single system exams can be used by any MD/DO, Blue Cross and Blue Shield of North Dakota, the carrier for Colorado will respond to any reasonable request for a presentation. This carrier also hopes to do a special mailing of the documentation guidelines. The guidelines may be used beginning October 1, 1997, and will be mandatory, i.e., this carrier will use them when reviewing records, for all E/M services provided after January 1, 1998.

These new guidelines will affect all physicians, not just specialists. As Dr. Steffen indicated, any physician can bill the new single system organ exams, not just a specialist. Physicians should note that the documentation guidelines not only include the new requirements for single system exams, but also those for the general multi-system exam. The content and documentation requirements for the multi-system exam have been changed and should be reviewed carefully.

Because the national specialty societies provided the input into the development of the documentation requirements for these single system exams, the AMA and HCFA have given the responsibility for training physicians to these same organizations. Even though all of the E&M documentation guidelines are being reprinted, only the examination portion has changed. The documentation requirements for the history and medical decision making portions remain the same.

Those members who attended the CMS Annual Meeting received a Medicare handout at the opening meeting of the CMS House of Delegates on Friday September 12, 1997. A copy of the new documentation guidelines was included in this booklet. The handout also included information on fraud and abuse, the Balanced Budget Act of 1997 and medical necessity guidelines for diagnostic clinical lab.

If you were unable to attend the Annual Meeting and would like to receive a copy of this booklet, please contact Marilyn Rissmiller at the CMS office at 779-5455 or 1-800-654-5653, ext. 2428. The documentation guidelines are also available on the internet at http://www.hcfa.gov/medicare/mcarpti.htm.

Copic Comment

by Jerome M. Buckley, MD
Chairman & CEO
Copic Insurance Company



Continued Rate Stability

By press time, those of you who are Copic policyholders should have received your 1998 Copic Rate Notice. We are very pleased to report that the average increase in Copic's 1998 rates has been held to only 1.75%...*the smallest average increase in Copic's history.* A $6 million distribution was also approved by the Board for 1998. The 1998 distribution will provide an offset of approximately 13% to your annual premium, and brings to $52.2 million the total amount returned to policyholders on business written since 1985.

Rate stability is good news indeed. However, I don't want any of you to miss the forest by focusing solely on this one tree. What I mean is this: rates for any type of insurance are driven primarily by loss experience. It's only through good loss experience that true rate stability can be maintained...and good loss experience comes only through careful, thoughtful practice that adheres to risk management principles and through vigilant protection of our hard-won tort reform. *You* must continue your careful, thoughtful, patient-oriented practice, and *we* will continue to provide you with the best risk management principles. And unlike other Colorado insurers, only Copic can claim to be both a driving force for tort reform and its staunch protector.

In 1998, physicians in Neurology, Orthopaedics, Urology, and Otolaryngology will see a decrease in rates, as will those in office-only specialties. These decreases can be attributed directly to improving loss experience. Conversely, worsening loss experience is at the heart of rate increases for physicians in Emergency Medicine, Neurosurgery, Pathology, Radiation Oncology, Diagnostic and Invasive Radiology, Gynecology-Major Surgery, and Family Practice-Minor Surgery.

Through lobbying and legislative activities, Copic is doing everything it can to protect tort reform from the attempts that would weaken it and drive up jury awards and losses. As practitioners of your respective specialties, you can greatly reduce your risk exposure (and thereby exert significant influence over claim losses) by incorporating proven risk management techniques into your practices. Copic provides a wealth of tools and techniques you can use to:

- Reap the improved defensibility rewards offered by a complete, accurate, and legible patient record;
- Ensure that true communication occurs when you talk to patients... with each of you both heard and understood;
- Stay informed of developments in your field;
- Engage your staff in a mission to refine the ways in which your practice works to prevent dangerous and costly "systems failures";

When you take advantage of these opportunities, you'll see that the results are both immediate and far-reaching... improving the quality of care for your patients, reducing your chances of being involved in a lawsuit, and decreasing your rates. I applaud each of you for your efforts and challenge you to take them to the next level.

No commercial insurer can equal Copic's commitment to Colorado physicians. We were here before the medical liability crisis of the early '80s. We were here, helping solve the crisis with risk management and tort reform, for the 1,250 physicians who were left hanging when the commercial insurers abandoned the state. We are there now, protecting your personal, professional, and financial interests. And we'll be there in the future...standing ready, willing, and able to assist you in any way possible. There before. There then. There now. There in the future. That's stability.

Obtaining a birth certificate now is easier in Colorado

It is now easier to obtain a certified copy of a birth certificate in Colorado. Requests can now be telephoned or faxed to the Colorado Department of Public Health and Environment. Other information on how and where a birth certificate can be obtained in Colorado is also accessible on the Internet at http://www.cdphe.state.co.us/hs/cshom.html.

A $15 fee is charged for obtaining the first copy of a birth certificate and $6 for a second copy obtained at the same time. There is a $5 fee for orders charged to Visa, Mastercard, Discover or American Express, the credit cards accepted for telephoned or faxed birth certificate requests. Pocket-sized birth certificates are only available for persons born in Colorado since 1962.

Either visit the department's Vital Records Office at 4300 Cherry Creek Drive South, Denver, or have your credit card ready to request a certificate by calling (303) 692-2224 or faxing 1-800-423-1108.

Requests must be submitted only by the individual named in the certificate or his or her parents; grandparents; stepparents; siblings; spouse; adult children or grandchildren; stepchildren; legal guardian; legal representatives of any of the above; or by genealogists who have appropriate credentials and who represent family members.

1997-98 HIV/AIDS Clinical Training Program

The Colorado AIDS Education and Training Center has created a web page dedicated to providing information about its 1997-98 Clinical Training Program. The program is designed to improve practitioners abilities to provide ongoing care to their HIV-infected patient and to increase the number of practitioners working with HIV-infected persons throughout the Rocky Mountain region.

The standard HIV clinical training course is three days in length. The training is offered three times a year (October 22-24, January 21-23, 1998, March 18-20 and May 4-5) and is restricted to 10 practitioners per program. A morning of didactic training is followed by two and one-half days of clinical rotations at Denver Health Medical Center, University of Colorado Health Sciences Center or Veterans' Administration Medical Center. There are a number of other sites that can be visited.

CME credits are available.

Please check the Colorado AIDS Education & Training Center at http://www.uchsc.edu/sm/aids/colorado.htm for more information. Or call Jackie Brinkman at (303) 315-2516.

Colorado Women's Health Campaign created to educate women

The Colorado Women's Health Campaign has been created in response to the growing needs and interests of women surrounding issues of aging and health. The campaign, which focuses on breast cancer, cardiovascular disease, osteoporosis, menopause and depression, is designed to educate women about how they can enhance and protect their health.

Nearly 60 health agencies, professional medical associations and voluntary organizations are collaborating with the campaign to highlight the importance of nutrition and physical activity to women's health.

The campaign will educate women about what tests and screenings will help them to identify diseases and conditions in their earliest stages when they are treatable. It will provide forums and events to enhance awareness.

Colorado is among the first of thirteen states launching women's health campaigns. For more information about the Colorado Women's Health Campaign or to become a volunteer, call 1-800-688-7777.

John L. Sherman, MD, installed as component society president

John L. Sherman, MD, was installed as the El Paso County Medical Society President for 1997-98. A radiologist from Colorado Springs, Dr. Sherman graduated from Tufts University. Also installed were Alan D. Rapp, MD, as President-elect, John D. Burrington, MD, as Vice President, Fred M. Feinsod, MD, as Treasurer, and Edward Fitzgerald, MD, as Secretary.

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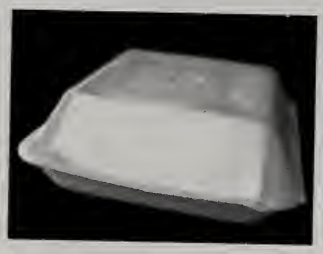
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04/0797

RUMINATIONS

(**def:** chewing again what has been chewed slightly and swallowed; to **REFLECT**)

*by **Bill Pierson**, Managing Editor*

"One small box. . ."



People long to travel (at least, many do). We've said for years that travel broadens a person, and I've been giving this a lot of thought lately. However, travel may not be such a good thing after all. For instance, if you long to go to a place to see what it's like, there is a lot of good for a person just in that longing; i.e., it gives you something to work for or toward. Many people have said for years that "Anticipation is greater than realization", and in a lot of cases this is certainly true. Fortunately, it has not been the case in my travels, because the places I go are places for which I have very few well-founded expectations. I don't know what to expect but I am anxious to experience.

Actually, travel may not be such a good thing because in anticipation of visiting a place new to you, your imagination creates a picture of the place, based on what you've read and heard. When you've been there, personally, all illusion is gone and you are left with only stark reality. Some times, the illusion was much better.

There used to be a joke that said "The only way I'll ever see that place is in the *National Geographic* ." That magazine has always been different because of outstanding photography. Television travel and nature programs do excellent work of this sort, but there's a major difference in seeing pictures versus "being there" to get the feeling of the place. It's something we can never change because we have to be among the people who occupy a "place" to honestly get the picture of the place. As an example, New York is nothing without the people, their hustle and bustle, the tall buildings, the seaboard, the difference in cultures there and here, wherever "there" and "here" may be.

Television can do wonderful travel and educational programming, but with their whiffy electronic imaging, there's nothing for the imagination to do. All the pictures are supplied for you, so your mind has nothing to do except absorb the information on the screen. I am afraid we have a nation almost full of people just waiting to see what television is going to show them and tell them today, also shaping their reaction and expectations along the way. Travel? Why bother?

So I have decided that when I travel I am going to some other place to see and feel the people's influence and see how their "place environment" affects the way they live and act. I love the varying cultures found in the many and diverse spots around the globe. That's what makes the great difference in locale, and, that's why I can enjoy going back to a place I've already visited: the people are constantly changing. Sometimes the real enjoyment of visiting places comes from the people you take with you to share with you what you are seeing and feeling. People do make the difference.

Following the death of Princess Diana I could relate more closely to the people in their mourning, the ceremonies at Westminster and the funeral procession because just a scant six months ago Tim Roberts (CMS Director of Membership Information Services) and I had been there. I knew the funeral route; I knew how long the route was and how difficult it must have been for those walking with the procession. On television, in the newspapers, on the Internet, I saw enough of these images that I began to get the feeling that it was all in my neighborhood. But having been there helped me understand. **I could feel a lot of what these people felt.**

One time in Bermuda I met a New Zealand scientist... studying the effects on the ocean food chain caused by a discarded fast-food styrofoam sandwich box. One small box thrown into the ocean acts as a new platform for algae, thereby diverting living organisms from other ocean plant life which depend on the algae to attract their food. This one small box (which has an unknown life-span because the styrofoam doesn't break down) can alter the food chain for all eternity. I wouldn't have known that had I not gone there and met someone there who cared and was studying the matter. That styrofoam sandwich box made a major impact on me, and I am very happy that in such a circumstance I can say

"Been there. Done that."

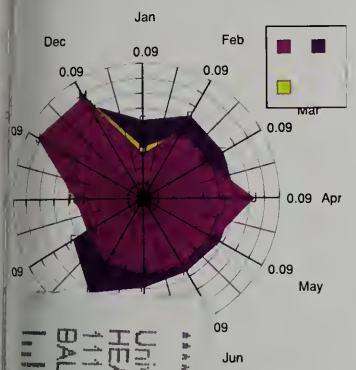
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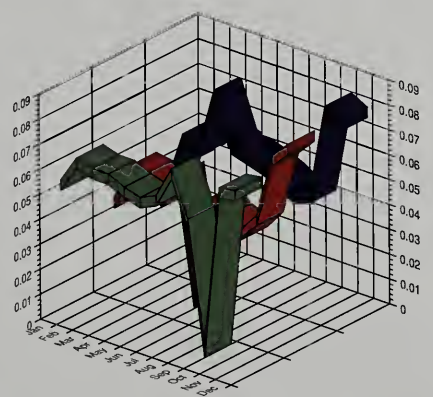
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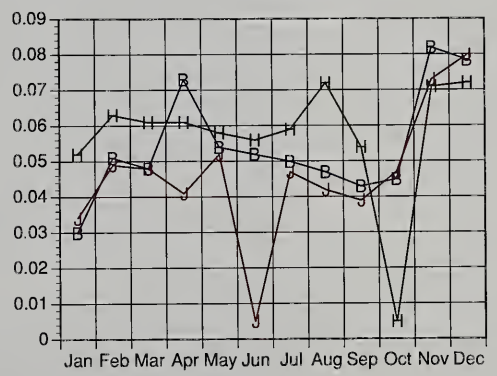
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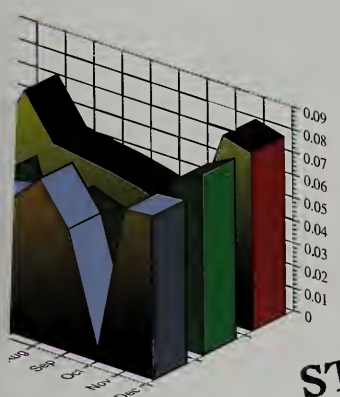
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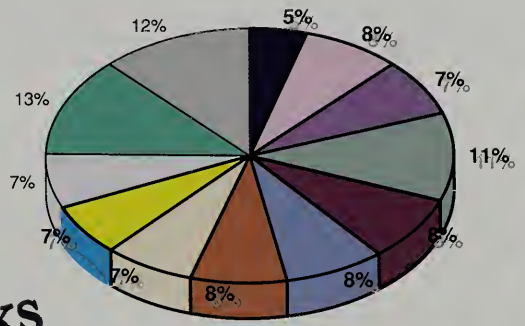
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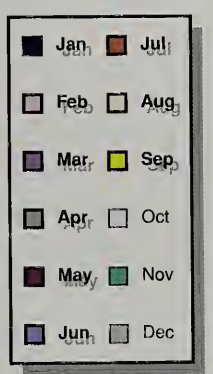












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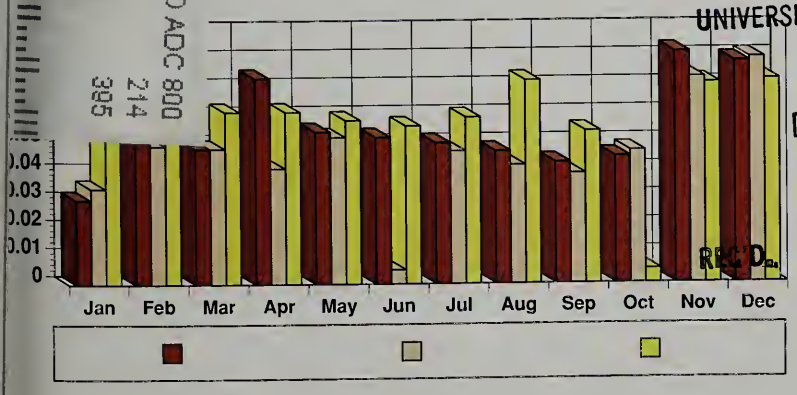
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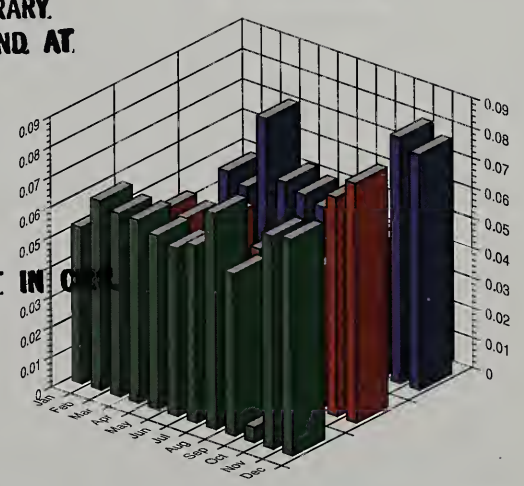
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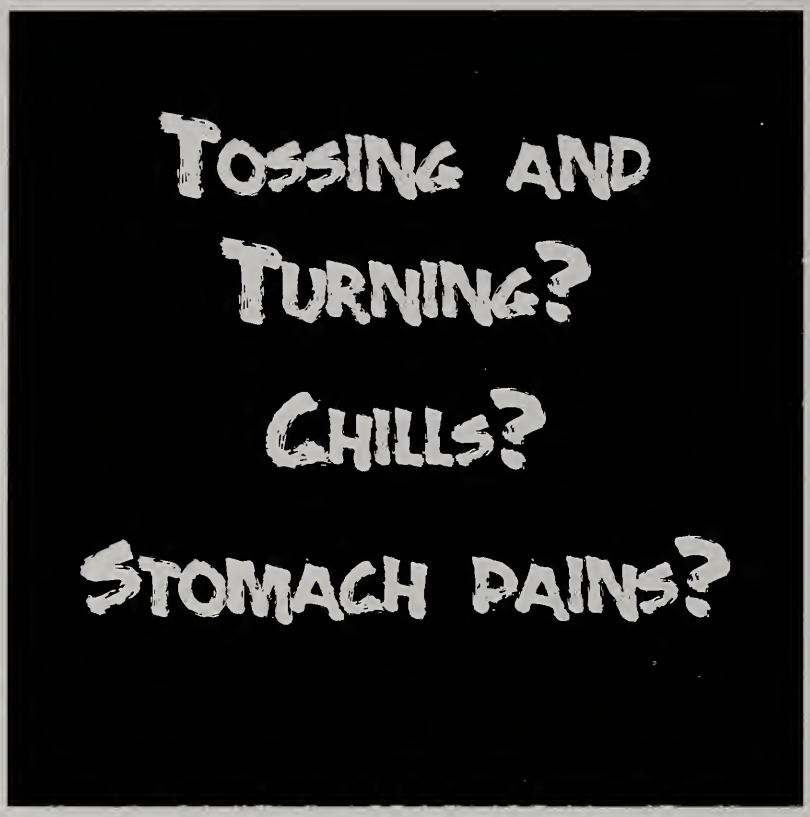
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This Issue:

HMO: To be or not to be? by CMS President Gary D.VanderArk, MD ..... **page 401**
Reversing the perception at CU by Richard D. Krugman, MD ..... **page 406**
Accountability: How will we do it? by Ned Calonge, MD ..... **page 411**
An evening with a pioneer Denver physician Archives-Seymour Wheelock, MD..... **page 420**



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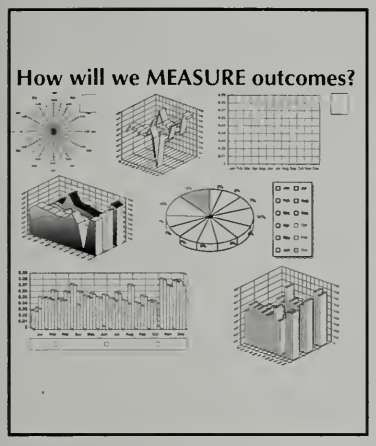
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COLORADO MEDICINE

November, 1997 Volume 94, Number 11



Cover Story

Patient/physician advocacy and outcomes measurement come together to create a new form of accountability in Colorado health care.

See page 411

In This Issue...

401 **HMO: To be or not to be?** Building healthy communities must start now, and HMOs must play a role by "standing the incentive structure on its head".

Gary D. VanderArk, MD
President, Colorado Medical Society

406 **Rape within a battering relationship**: rape is a crime of violence when perpetrated by a stranger or a significant other. Physicians should be aware of this form of domestic violence.

Kelsey S. Barnes, LCSW

408 **Reversing the perception of the CU-Health Sciences Center** – the Area Health Education Center (AHEC) System continues its long tradition of serving Colorado.

Richard D. Krugman, MD
Dean, University of Colorado School of Medicine

409 **After 27 years CFMC is still growing** – CMS creation, it now serves Medicare, Medicaid, Tricare

418 **Moving toward consumer driven health care** – recent reports indicate that patient concerns are being heard by Colorado managed care plans.

Joel M. Karlin, MD

420 **An evening with a pioneer Denver physician** – when the west was wild, doctors in Colorado got the job done. A colorful story about Dr. John Elsner's practice in the 1800's.

Departments

401 President's Letter
405 Executive Director's Update
407 Colorado Physician Network
417 CMSA
420 Archives
425 Copic Comment
426 Medical News
428 Classifieds
430 Health Care Financing

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President's Letter



Gary D. VanderArk, MD
President, 1997-1998

On October 3rd I was invited to represent the CMS at the annual meeting of the Colorado HMO Association. I shared with them the events of our annual meeting at Snowmass and challenged them to work with us in building healthy communities.

I find it ironic that they are called HMO's - Health Maintenance Organizations - when so little of their emphasis is placed on health or maintenance. So I would like to share with you my message to the HMOs.

"Health status improvement during the next century will derive from the extent to which we create new models of health intervention. These models will depart from our century-long emphasis on medical care, toward a multi-sectorial approach to health enhancement, comprising not only health care efforts, but also other sectors including economic, social, educational, environmental and cultural modification. A society that spends so much on health care that it cannot or will not spend adequately on other health-enhancing activities may actually be reducing the health of its population.

You call yourselves HMOs but 80% of your expenditures are for treating chronic disease. That's not providing health; it's treating sickness. It would be far better for us to ascertain what the community really needs and wants. Some of these needs and wants will fall outside of traditional clinical areas of expertise . . . i.e., domestic violence, elderly housing or a wellness program. The mission of HMOs is not really a matter of strategic choice. Instead, the mission should be optimization of community health. This requires an emphasis on primary care, health promotion and prevention. If the banker, the lawyer and the chamber of commerce can find civic virtue in their hearts then so can providers and insurers.

We must begin to build healthy communities now. There's more at stake than income and turf: the health of the nation is at stake. Social systems in this country are collapsing. Drugs, alcohol violence, gangs, teen pregnancies are ubiquitous. We can't afford to do it any other way. In extending such altruistic characteristics, the community lowers long term health care costs and increases the resources available within the health care network. And, finally, the bottom line is it's the right thing to do."

I think that, in the past, we have had trouble seeing the forest for the trees when it comes to dealing with HMOs. We quibble about individual branches when we're in danger of losing the whole forest. So, I asked them to work with us on our agenda of access and accountability.

Kaiser has demonstrated concern about access and I applaud their school-based program in the Denver metropolitan area. The Blues have also shown concern for children with the programs supported through their foundation. More can and must be done.

Our big collaboration with the HMOs in 1997 was killing the Medicare Demonstration Project for metropolitan Denver. Well, I think we need a demonstration project with the HMOs. My demonstration project, however, would not be about competitive bidding but about accountability. We could do a fundamental innovation truly deserving the overused phrase "paradigm shift" by aligning financial incentives and rewards for improved outcomes. This technical change would stand much of our incentive structure on its head and result is considerable shifts in provider behavior aimed at improving overall health outcomes. We could start with Medicare. By collaborating on outcomes, we could save millions and demonstrate to the nation that Medicare can be saved.

We have already begun. Our Accountability Committee is working with the HMOs on a diabetes outcomes project which will prove our ability to work together.

We have a vision and a task!

HMO (Health Maintenance Organization):

To be or not to be?

LEGAL UPDATE

from Gelt, Fleishman & Sterling P.C.



A. Craig Fleishman, Managing Director

Antenuptial and postnuptial agreements - Protection and security Part II

In general, antenuptial and postnuptial agreements are treated by the courts in the same manner as other contracts. However, if provisions of the agreement concerning maintenance (alimony) or attorney's fees are determined by the court to be "unconscionable", they can be modified or set aside. Further, the agreement is not valid unless the party seeking to enforce the agreement has made a full and fair disclosure of his or her assets before the document was signed.

Anyone who has gone through the emotional trauma of a divorce with its attendant financial costs is well aware of the benefit of an antenuptial or postnuptial agreement, if such a document can be agreed upon by the parties without creating a feeling of anger or resentment because such a document has been proposed. The diplomatic communications skills of the attorney engaged in negotiating and preparing the agreement is critical to minimize the potential of discord. If we can be of assistance to you in advising you of the merit of an antenuptial or postnuptial agreement, please do not hesitate to contact us.

As it is important to protect your assets going into a marital partnership, it is imperative for you to consider protecting your assets when you go into a business partnership. For these reasons, we recommend you engage legal counsel to help you draft by-sell agreements, employment contracts, retirement plans and appropriate personnel policy manuals.

For further information please contact:

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CMS Med Fax®
by Montgomery Little and McGrew, P.C.
legal counsel to the Colorado Medical Society

HCFA responds to questions about new E&M Documentation Guidelines

As reported last month in *Colorado Medicine,* new Medicare E & M Documentation Guidelines were released by HCFA and the AMA earlier this fall. The CMS Health Care Financing Department has received calls with questions regarding these guidelines. Below you will find a list of frequently asked questions on the guidelines and HCFA's responses.

Q: How do you know which documentation guidelines (DG) exam you qualify for? How will the reviewer know which one, general multi-system (GMS) or single organ system (SOS) you used?

A: HCFA considered requiring a modifier to differentiate which exam, GMS or SOS, was being performed. The Carrier Medical Directors strongly supported the modifier. HCFA has chosen not to do so at this time.

Q: Do you have to indicate whether you are performing a GMS or SOS exam?

A: No, but if you note what kind of exam, GMS or SOS, is on the chart it could help you. It is not required, but would be helpful.

Q: Will physicians be able to re-transcribe or translate "illegible" medical records?

A: That is what happens now but HCFA would like to minimize this practice. HCFA may change the regulations to say legible name including signature or initials. Concerning ID requirements, computer generated signatures and stamps are permissible.

Q: Can physicians' diagnostic interpretations all be printed by a computer?

A: Yes.

Q: If you order a test that turns out to be negative, is that then a screening test?

A: No. What will determine the medical necessity is the chart documentation on the rationale for ordering the test, whether stated or inferred.

Q: Do you have to document all the elements within a bullet?

A: No, for example in the bullet examination of liver and spleen, you must perform them both but need only document one, liver or spleen.

Q: Under the GMS ENT organ system otoscope exam, could you perform the examination of the tympanic membrane only?

A: No. The expectation is that all listed elements of the bullet be performed, but only one element needs to be documented. Consider the following:
Bullet = element. Bullets/elements may have more than one component.
For performance: some elements are mandatory (indicated by "and"), some are optional (indicated by "or").
For Documentation: document a single component within the element.

Q: Do you need to perform and document all five sub-bullets under auscultation of the heart section of the GMS Cardiovascular system?

A: You must examine all five bullets under auscultation for a comprehensive exam. Indention is not relevant. You are only required to document two of the bullets listed under the cardiovascular organ system to qualify. The same thing holds true for the Lymphatic and Musculoskeletal organ systems.

Q: Can you examine just one of the musculoskeletal areas? Are there a total of 24 potential bullets?

A: Yes. This is an application of the clause, "Unless specific directions limit the exam," found in the requirements of the comprehensive examination under the GMS guidelines. The specific requirements in this case state, "Perform four of the following six" in the SOS exam.

Q: For example in GMS Musculoskeletal exam area #3, upper extremity, does this mean a separate note for each of elbow, wrist and fingers? Does an extremity mean every joint or selected joints?

A: No, every joint is not always required. Conceivably for a level 3 exam, you could do only one joint. For the lower extremity it could be either knee, ankle or foot. The "(s)" after joint(s) and muscle(s) found in the SOS Musculoskeletal exam is intended to say all joints are not required to be documented. No

(Continued on page 3)



Med Fax: Medico-Legal News

by Karen B. Best, Esq., an associate with the law firm of Montgomery Little & McGrew, P.C.

This column contains information concerning topics of general interest in the medical-legal field. For further information or help with specific problems, please contact Montgomery Little & McGrew, P.C.

New Regulation for PIP Examinations

This year the legislature enacted a new regulation implementing the Personal Injury Protection (PIP) examination program, which is part of Colorado's no fault statute. C.R.S. 10-4-701, et seq. (the Colorado Auto Accident Reparations Act), and C.C.R. 5-2-9. The regulation is intended to create a method of finalizing disputed PIP claims and to decrease litigation over the question of what constitutes reasonable and necessary treatment. Whether it accomplishes those purposes remains to be seen. It does however set forth specific rules about obtaining PIP examinations, the contents of reports, and the effect of the opinions expressed in those reports.

The PIP examination program results from an adversarial system which found injured parties and insurance companies at an impasse over what treatment was appropriate (reasonable and necessary) for injuries suffered in motor vehicle accidents. Some treaters have been perceived as patient advocates willing to continue treatment indefinitely without seriously questioning the patient's complaints, while some insurance companies have been perceived as villains interested only in the bottom line. With exceptions of course, for every treater who thought the patient needed surgery or 15 more weeks of physical therapy or chiropractic treatment, there was an IME doctor hired by the insurance company who thought the patient's complaints were altogether functional, or caused by a pre-existing condition, or would not benefit from further treatment. When the parties were unable to resolve their differences, litigation (or arbitration) was the means available for resolving the dispute. The claims asserted in this type of litigation are distinct from and go beyond the claims in any underlying lawsuit arising from the accident itself, and can involve claims of breach of the insurance contract and bad faith.

The resulting regulation implements a statutory PIP examination system similar to that already in place in the worker's compensation arena. When a PIP claim dispute arises, either the patient or the insurer may request an IME. A dispute arises when either the claim is denied or is under investigation, or when the patient is dissatisfied with the findings, opinions and conclusions of a PIP review panel member. Once a party requests an IME, he cannot withdraw the request, unless the other party agrees or the dispute is resolved. From a panel of IME providers (doctors, chiropractors, physical therapists, dentists, and other providers) which is already in place, program administrators select five names. The party requesting the IME specifies the professional specialty of the health care practitioner who will perform the PIP examination. Where practical, and with some exceptions, the specialty will be the same as that of the treating provider whose treatment, opinions, diagnosis, plan of treatment, prognosis, statement of causation, or recommendations are under review. The debate over the specialty of the IME examiner continues; chiropractors in particular favor a system where only chiropractors review the opinions of other chiropractors. Each party eliminates two names from the list, a procedure much like that used in jury selection. The remaining provider timely performs the IME and reviews records identified and submitted by the parties. The IME provider prepares a report addressing salient and pre-determined issues such as: reasonableness, necessity, causation, apportionment, diagnosis, prognosis, plan of treatment, need for essential services, ability to work, opinions and recommendations.

Here's the pay-off: the findings, conclusions and opinions of the IME provider are presumed to be correct. Of course, there are ways to challenge the report, and there are so many steps to follow in the process that there are opportunities to disagree along the way. However, in most cases the report *should* mark the end of the dispute. Ideally, the parties will resolve their dispute, thereby avoiding and reducing litigation.

The process is only as good as the individual IME providers available to perform the IMEs. By one report from some time ago, about one half of the panel was chiropractic, involving about one quarter of the licensed chiropractors in the state. The more conservative specialties had not yet come on board in large numbers. This may have changed by now.

The regulation is more detailed than space allows. If you want additional information, please contact Montgomery, Little & McGrew, P.C.

(E&M Guidelines continued from page 1)

parentheses appear in the GMS Musculoskeletal section, but they should be there.

Q: If a patient refuses an exam, is that permissible as a documented element?

A: On a case by case basis, but not if it is routinely used for all patients.

Q: Emergency physicians would usually use the GMS. Often the rectal would not be medically indicated. Could we add "if indicated" to the bullet for the rectal exam? Do you have to do a rectal exam to meet level 5 documentation requirements?

A: No, but you may not use the GI system to qualify. You don't have to do it, but you then can't claim that as one of your body areas (BA)/organ systems (OS). You need also not do pelvic or scrotal exams on every patient to get a level 5. You must have nine other BA/OS to qualify for a comprehensive exam. The SOS Cardiovascular exam does not include a rectal under the GI organ system. This might be another alternative to consider.

Q: Can you qualify for the rectal exam bullet if you document "rectal deferred," "patient refused rectal," or "rectal exam contraindicated?"

A: HCFA considers there to be a difference between "rectal exam deferred" and "patient refused rectal." One suggests physician choice and the other denotes patient refusal. As long as audits show you do not indicate "patient refusal" the majority of the time, you would probably get credit for the bullet. However, if there is a consistent pattern of similar patient refusals, auditors might question your integrity. Officially, for a comprehensive exam you must perform every bullet listed. If you can document "contraindicated" you are okay as long as you document the medical reason why.

Q: Is it permissible to simply state "normal" for any required bullet?

A: For any component a note of normal would qualify as long as you include all the required elements.

Q: Could you substitute other elements such as bowel sounds for those listed in a BA/OS?

A: No, document what you do, but you may not substitute.

Q: Consider the bullet for "oriented to time, place, person," can this be pulled out of the History of Present Illness (HPI) dictation?

A: Yes, if that is where it is written. But this is an examination point, not an HPI element. The two should not be confused.

Q: In the Neurology SOS, each of the Cranial Nerves is a separate bullet. But in the GMS, all 12 cranial nerves count as one bullet. Must you document all 12 cranial nerves to get credit for one bullet under a GMS?

A: Yes, you must do all 12 for that bullet in the GMS, but you could document "normal" except individually for those that are not normal.

Q: Do Teaching Physicians (TP) need to redo everything the resident does?

A: No. They can reference notes in the a resident's documentation. They do not have to rewrite everything. The TP must add value or be present for the key portion.

Q: Is it true the TP does not have to repeat a resident's history?

A: Just a note confirming the history taken by a resident is only okay for ROS and PFSH. The TP must personally do the HPI. Other ancillary staff can do ROS & HPI as well as a resident.

Q: Is using residents as scribes okay?

A: Okay, if the resident documents the participation and physical presence of the TP. Then the TP must sign the chart also.

Q: Where should we look for clarification of these issues?

A: The HCFA home page is the official source for this information. Visit HCFA on the Internet at: http://www.hcfa.gov/medicare/mcarpti.htm.

For additional information, please contact Marilyn Rissmiller in the CMS Health Care Financing Department at (303) 779-5455 or 1-800-654-5653.

Roy Ennis Wolfe, MD

Roy E. Wolfe, MD, died on October 26. He was an active emeritus member of the Colorado Medical Society. Dr. Wolfe received his M.D. from the University of Colorado in 1939. He did his residency at the US Marine Hospital in Cleveland, Ohio and completed his internship at St. Lukes in Denver. A member of the Boulder Medical Society, Dr. Wolfe was a well regarded general practitioner in Boulder.

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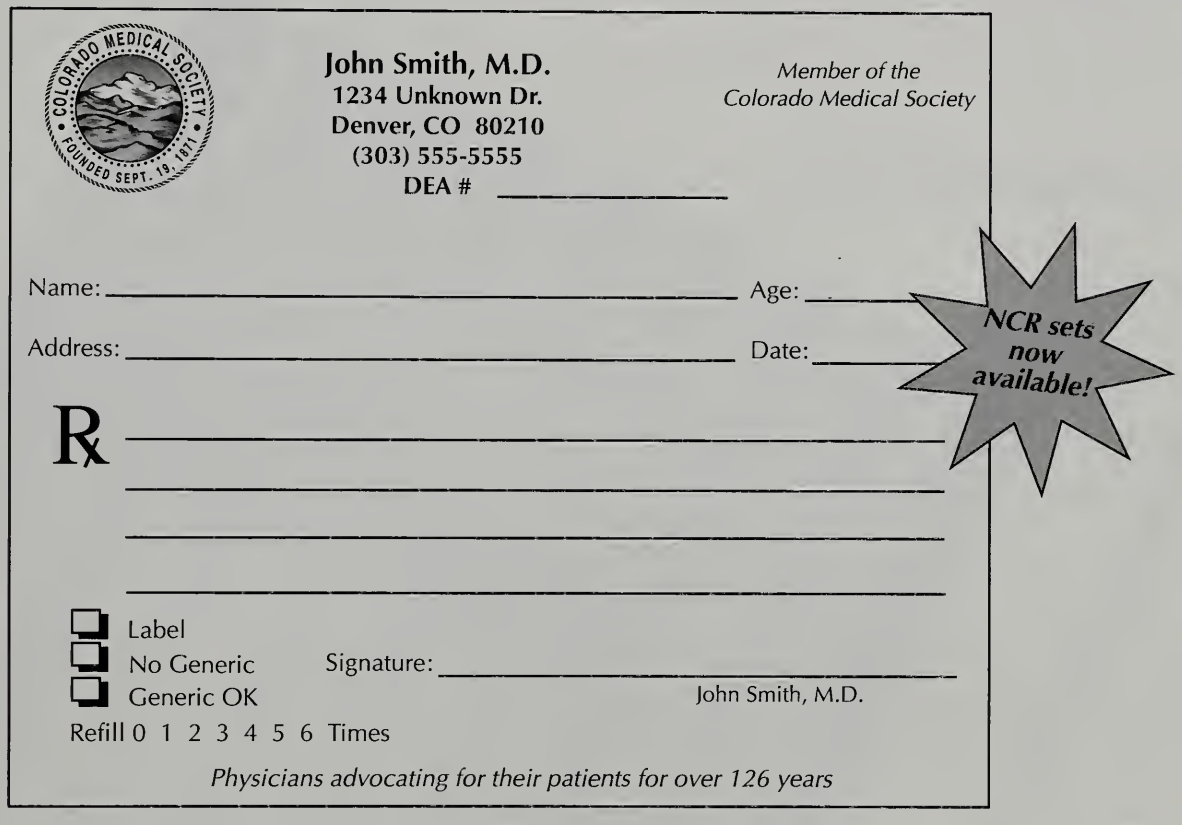
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March 25-28, 1998
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(406) 442-6556

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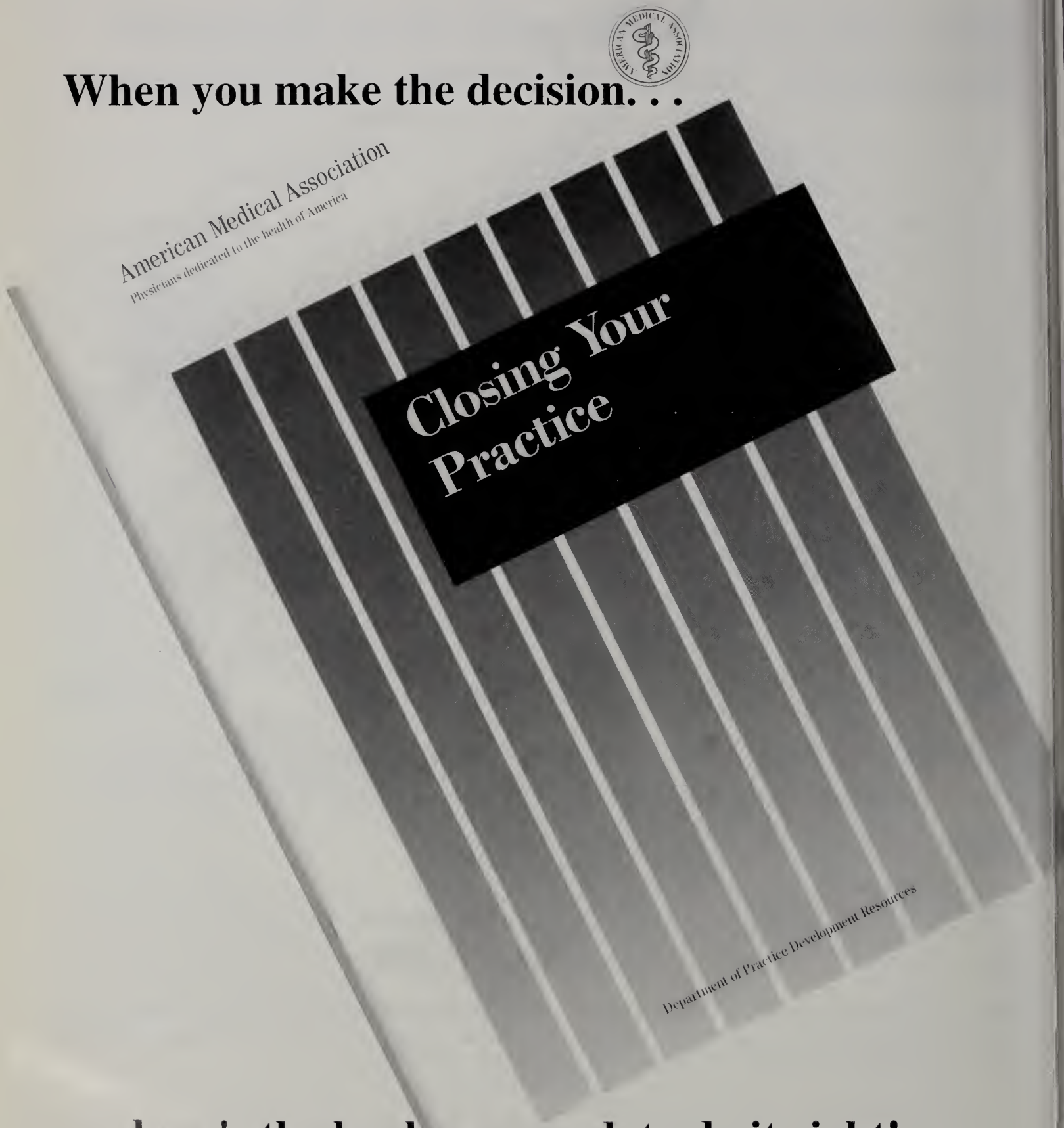
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When you make the decision. . .



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The AMA Department of Practice Development Resources has made available this booklet giving you the fiscal, legal and ethical answers to all those questions when you decide to close your practice. You can order the book by calling 1-800/621-8335. The order number is OP381689RY. Price of the book is $19.95 for AMA members, $24.95 if you are not a member.

Executive Director's Update



Sandra L. Maloney
Executive Director
Colorado Medical Society

Accountability
Accountableness
Accounting
Accountable
Answerable

Accountability. We talk about it, but just what is it. When I started in my present position (Nineteenaught ninety), I made a pledge to the Search Committee that I was going to make the Colorado Medical Society more accountable to its leadership **and** its membership. What did I mean? I meant that the CMS Officers, Board of Directors and staff were all going to be much more in tune with the needs and desires of the physician members. We have all worked hard to accomplish this, and I believe we have made a major accomplishment in this area. As examples:

- Our President's Component Visitations Program has been going for over seven years and it bears fruit every time the President and I make one of these visits.
- The CMS President's Planning Session, which became the CMS Leadership Conference has become much more sensitive to the issues which confront the medical professional and the ways in which CMS can address the issues and work toward solutions to the attendant problems.
- The yearly operating budget of CMS is much more finely tuned and we have succeeded in taking a major step toward rebuilding our cash reserves.
- Our membership has grown steadily, and much of the reason for this has to be the realization that CMS is being accountable to its members; thereby encouraging others to join and be a part of the solution.

These are just a few of the accountability issues as I perceive them, and have exercised my accounting to you, the members.

What else can we, as an organization, do to handle this "accountability" issue? As our 1997 Leadership Conference pointed out (see the leadoff article, ***"Outcomes In Clinical Practice"*** *by Ned Calonge, MD on page 412),* physicians are going to have to be accountable, but just how they do this is a big and important question. CMS can help in a number of ways, as emphasized by every one of our presenters, including President VanderArk.

What should our first step be toward this kind of accountability?

- We (CMS) must be helping its physician members with the gathering, handling and using the outcomes data. We are an organization that has intelligence and might enough to be able to do this.
- We (CMS) must be sure that we are putting a physician at all bargaining tables when it comes to setting standards of practice or outcome measurements.
- We (CMS) must continue to be at the statehouse for every health-related issue that comes before the lawmakers, right from "gitgo", and we should be there even before that on most issues (actually writing or proposing such health care legislation we feel is necessary), forming the coalitions which can move some of these issues through the molasses-like mire of lawmaking.

Yes, these are the kinds of accountability that we have to remember and practice at CMS, in order that the new reality of "Outcomes Measurement" and full "Accountability" does not overwhelm Colorado physicians.

I'm extremely pleased to report that your Colorado Medical Society, through its leadership and its voluntary physician-member participation, is already doing all these things and more, and we're going to keep doing them with an accountableness in our accounting and fully accountable to our membership.

If you have questions, please call me. I'm answerable.

Rape Within A Battering Relationship

by Kelsey S. Barnes, LCSW

"A husband cannot be guilty of raping his wife because, in marrying, she had 'given herself in this kind unto her husband.'"

So wrote Sir Matthew Hale, a British judge, several hundred years ago. Unfortunately, attitudes have changed slowly in the intervening years.

Rape is forced sexual contact - whether intercourse, oral, or anal sex - often intensified by physical force or threats of harm. It is a crime of violence whether the rapist is a stranger or a husband.

The legal system has been slow in acknowledging this fact. It was not until the 1980s that Colorado even had a law protecting wives from marital rape. Today, although wives who are raped by their husbands have the same protection under the law as victims of stranger or acquaintance rape, many people still do not acknowledge rape within marriage.

What is the relationship between marital rape and domestic violence? According to a study done by Jacquelyn Campbell, anywhere from 33-59% of all battered women are also victims of marital rape. In a survey conducted by Finkelhor and Yilo, of 323 women who were victims of battering and marital rape, all but three identified the rapes as the most devastating aspect of all their abuse. In addition, Irene Frieze, Nancy Shields, and Christine Hanneke found that wives who are raped are more severely battered than wives who are not sexually assaulted and Jacqueline Campbell found that these wives were significantly more likely to have been beaten during pregnancy.

Medically, Peggy Alford, found that bettered women who had been raped by their partners were significantly more likely to suffer from certain health problems than were battered women who had not been raped. These problems include AIDS, sexually transmitted diseases, urinary tract infections, decreased sexual desire and pleasure, hemorrhoids, and other gynecological problems.

Victims of marital sexual assault also face the same trauma symptoms as do other rape victims. In general, victims of sexual assault are thirteen times more likely to commit suicide than the broader population. Most alarming, however, is the finding that victims of marital rape are at greater risk of being murdered by their husbands, or of murdering them, than battered women who are not sexually violated.

Possible Indicators of Sexual Abuse Within A Battering Relationship

Medical indicators include redness, swelling, bruising, or bleeding to external genitalia, the vagina, the anus, the cervix, the abdomen, the breasts, and the upper thighs; sexually transmitted diseases; pelvic inflammatory diseases; or injuries that are inconsistent with the patient report.

If you suspect that sexual assault may be occurring within an ongoing relationship, take a domestic violence assessment and ask specifically about unwanted sexual contact. How these questions are asked is important. Never ask a woman if her husband or partner is sexually abusing her. Many women feel disloyal if they "accuse" their partner of rape. Other women don't even think of the abuse as sexual assault.

Ask general questions such as:

- Has your husband or partner ever forced you to have sex even when you told him no?
- Has your husband or partner ever forced you to engage in a sexual activity in which you felt uncomfortable, unsafe, or demoralized?
- Does your husband or partner threaten you in any way when you refuse to have sex?

Take a complete sexual history of the patient. Use multiple questions when asking about possible forced sexual activity. Describe specific behaviors for the patient and be comfortable in talking in explicit sexual terms. For example, ask if the patient has ever been forced by her partner to engage in any of the following behaviors against her will:

- fondling
- vaginal penetration or attempted vaginal penetration
- anal penetration or attempted anal penetration
- oral penetration or attempted oral penetration

(Continued next page)

Colorado Physician Network, Inc.



by David M. Martz, MD
President CPN

"RMHMO Is Number One!"

When Colorado Physician Network (CPN) selected Rocky Mountain HMO (RMHMO) as it's collaborative health maintenance organization three years ago, it was with the conviction that RMHMO had a proven track record based on unique core values consistent with our goals of patient advocacy and the primacy of the patient-physician relationship in decision making.

A recent survey (conducted by the Colorado Business Group on Health) of 11,000 Colorado participants in eight HMOs has convincingly confirmed that belief:

RMHMO ranked Number One with 29 out of 30 possible points in the 10 satisfaction categories.

And the rest?

Health Network of Colorado Springs was next best with 26 points, Kaiser Permanente 24, PacifiCare 23, QualMed 17, Prudential HealthCare HMO 15, HMO Colorado 13, and CIGNA HealthCare HMO 11.

Among the ten issues surveyed were overall satisfaction, attention given to what the patient had to say, ease of choosing a personal physician, quality of care and service, receiving care that the patient and doctor believed was necessary, getting referral to a specialist, and intention to not switch to another health care plan.

The Gold Standard!

We salute you, RMHMO, for establishing the "Gold Standard" in managed care! It is a pleasure to be associated with you, and a treasured opportunity to join together in spreading your program to the entire state of Colorado!

Rape Within A Battering Relationship *(Continued)*

• intercourse with another person.

Keep the questions simple, gentle, and direct. Requiring the patient to give elaborate explanations or descriptions may cause further trauma. Above all, do not use a judgmental tone or manner with the patient. Remind her that an assault is not her fault and even if she is married to her attacker, she does not deserve to be forced into a sexual act with which she is uncomfortable.

Special Considerations

It is important to remember that partnerships include more than just heterosexual marriages. Gay, lesbian and bisexual people can also be involved in battering relationships and can be at risk of being sexually assaulted by their partners. Adolescents are another extremely vulnerable group. Both domestic violence and sexual assault are on the rise among adolescents. Finally, it is important to screen for sexual assault among elderly patients where any kind of abuse may be present. Elders may be sexually assaulted not only by partners, but by caretakers or children.

Why It Is Important for Doctors to Screen for Sexual Abuse

Often, victims are more likely to talk with their doctors and doctors are sometimes in the best position to assist the victim in getting the help she needs. Many resources are available and while doctors do not need to be experts on marital assault, they do need to know where to send patients for help. Know the local sexual assault and/or battered women shelters in your area. If you do not know what shelters are in your area, contact the Colorado Coalition Against Sexual Assault at (303) 861-7033.

For updated information on state laws and for a marital rape information packet, contact:

National Center on
Women and Family Law
799 Broadway, Room 402
New York, NY 10003
(212) 674-8200

Reversing the Perception of the CU-Heath Sciences Center

by Richard D. Krugman, MD, Dean
University of Colorado School of Medicine



"I'm pleased to now have a strong outreach support system in place. . . "

This year marks the 20th anniversary of the Colorado AHEC (Area Health Education Center) System.

A partnership between the University of Colorado Health Sciences Center and five community-based AHECs in the state, it links CU's academic resources with local health care providers and organizations.

Over the years, the AHEC system has done a wonderful job of providing the support that the communities and providers need. It also has played an integral role in enhancing the clinical experiences of our students and preceptors. Today, it is considered one of the model programs of its kind in the country.

I served as the first executive director of the Colorado AHEC system back in 1977.

I hit the road then and, along with a small team of Health Sciences Center colleagues, traveled throughout the state to gain support for the program. Twenty years later, I'm still traveling the state to meet with our students and preceptors, as well as other providers, community leaders and legislators.

At last count, our community outreach team, which includes representatives of the Schools of Medicine and Nursing, University Hospital and the AHEC system, had made 74 trips over the last five years. In all, we've been in 85 Colorado communities and a total of 154 health care facilities. We've now visited every hospital and most of the community health clinics, county nursing services and public health departments in the state at least once, and in most cases, several times.

Although I still enjoy getting out around Colorado to meet with local physicians, preceptors, residents and students, I'm pleased to now have a strong outreach support system in place to enhance my efforts. At the Health Sciences Center, they include Dr. Gerald Merenstein, our new senior associate dean for education; Dr. Curt Stine, an associate professor in the Department of Family Medicine and the associate director for medicine to the Colorado AHEC System, and Dr. Gwyn Barley, the course director for our Primary Care curriculum.

A year ago, the AHEC system also created a team of physician education consultants out in the field to help facilitate both clinical experiences of medical students and continuing medical education opportunities for physicians around the state The medical education consultants all have had long and strong ties to their communities and medical colleagues. They bring an important dimension to our efforts to foster and expand relationships between community physicians and the School of Medicine.

In addition to enhancing continuing medical education and serving as a liaison with community physicians who serve as Clinical medical faculty for our students, the physician education consultants have been helpful in identifying prospective preceptors and clinical training sites. They also have actively participated in our medical school curriculum planning. Our four physician education consultants include:

- **Dr. Robert A Linden** of Alamosa who practices internal medicine at Valley-Wide Health Services and is a member of the medical staff at the San Luis Valley Regional Medical Center. He is our senior preceptor, having been training our students since 1982.

(Continued following page)

After 27 years CFMC is still growing

CMS creation, it now serves Medicare, Medicaid, Tricare

by Erich Kirshner
Colorado Foundation for Medical Care

The Colorado Foundation for Medical Care (CFMC), created by the Colorado Medical Society House of Delegates in 1970 as a Peer Review Organization, is now a thriving medical quality improvement organization serving the Medicare, Medicaid, and TRICARE (CHAMPUS) programs.

CFMC, a private, non-profit organization, has 120 employees and annual revenues of $6.5 million. Approximately 400 practicing physicians across Colorado serve as CFMC consultants. Employees include physicians, registered nurses, health economists, research analysts, epidemiologists, biostatisticians, data processing experts, and health management consultants.

For the HCFA (Health Care Financing Administration) Medicare program, CFMC conducts numerous Health Care Quality Improvement Projects (HCQIP). On these clinically-based projects, CFMC collaborates with physicians, hospitals, long-term care facilities, and managed care plans. The projects focus on improving the quality of care delivered to Medicare beneficiaries. Ongoing projects focus on many clinical topics including diabetes, peptic ulcer disease, cancer care, restraint use in nursing homes, congestive heart failure, and influenza.

Regarding Medicare, CFMC also provides an 800 number for beneficiaries to call if they have quality-of-care concerns (1-800-727-7086).

For providers, Lucia Hammer, CFMC's Associate Director for Medicare, is available to speak to groups about the government's investigation of fraud in the Medicare system. Hammer explains the nature of the investigation, and offers strategies for avoiding this type of government scrutiny.

For Medicaid, CFMC provides utilization and quality review services to the Colorado Department of Health Care Policy and Finance, the state's Medicaid manager. CFMC divides the Medicaid work into two internal departments, Long-term Care and Acute Care. These efforts help ensure that limited state resources go to qualified clients.

The Department of Defense's TRICARE (formerly CHAMPUS) program, uses CFMC as a subcontractor to the Pennsylvania Peer Review Organization (PePRO) which continues to supply an appeals process for providers. The subcontract also includes mental health facility certification responsibilities.

"We have come a long way since our formation in 1970," said CFMC Chief Executive Officer Arja P. Adair Jr. "Our emphasis on quality assurance and quality improvement is exactly where patients, providers and payers want us to be -- assisting in changing patient care and patient outcomes for the better."

Reversing the Perception

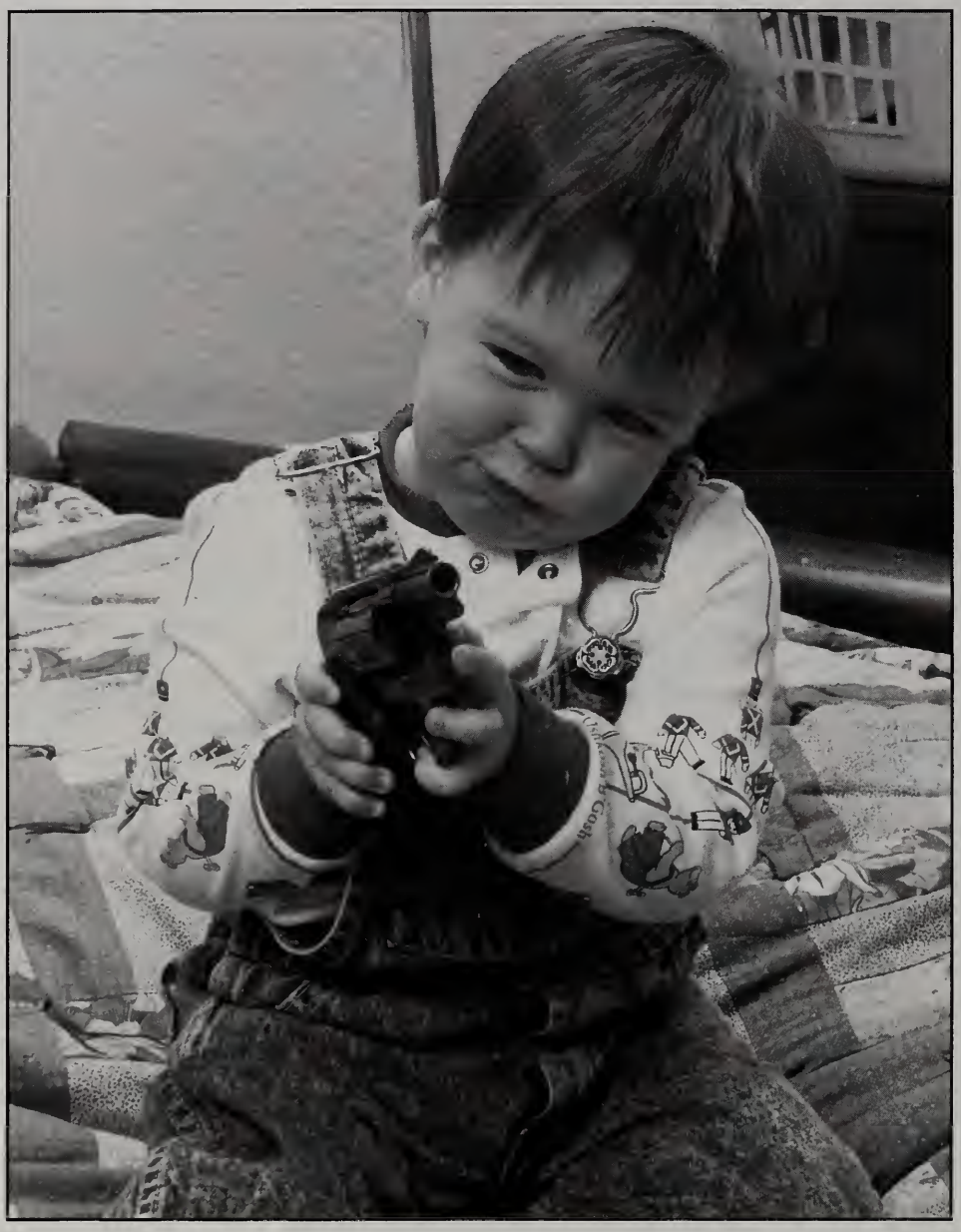
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- **Dr. Ted Dickenson** of Montrose, a general surgeon who currently has medical staff appointments at Montrose Memorial Hospital, Delta County Memorial Hospital and University Hospital. In 1987, he received the Golden Apple Award from the CU School of Medicine as the outstanding clinical teacher in surgery.
- **Dr. Marc Ringel** of Brush, a family physician for more than 20 years, who served for almost 10 years on the faculty of the North Colorado Family Medicine residency program at Greeley. He is currently practicing part-time in Brush and consulting on rural health issues, informatics and telemedicine.
- **Dr. Grady King (Kin) Snyder, Jr,** of Rye, who practices family medicine in Colorado City and was on the faculty of Southern Colorado Family Medicine Residency in Pueblo from 1991-1995. He also provides part-time coverage at the Colorado State Hospital and is a clinical assistant professor with the University of New Mexico School of Medicine.

Each of our medical education consultants is associated with one of our regional AHEC offices and participate as they can in our regular outreach trips around the state. As a group, they are helping us reverse the public and professional perception that the Health Sciences Center's focus is only at Ninth Avenue and Colorado Boulevard in Denver, and not around the state.

If any component society of the Colorado Medical Society would like any of us to visit and discuss the current state of medical education and/or the state of the School of Medicine, I'd be delighted to hear from you.

Kids and Guns Just Don't Mix...



Doctor, are you talking to parents about guns in the home?
Remember:
Separate guns and ammunition,
Lock up guns and ammunition separately,
Use trigger locks

If you keep a gun, empty it out, lock it up!

This message brought to you by the Colorado Medical Society,
Task Force on Youth

For more information call Suzi Shevell at 303-930-0407 or 1-800-654-5653

An introduction

by Gary D. VanderArk, MD
President, 1997-1998

As we approach the end of this decade, this century and this millennium, the most important buzz-word in health care is "Accountability". The Leadership Conference of the Colorado Medical Society for 1997 was devoted extensively to the subject of accountability. In planning that conference I was delighted to discover that Colorado has a great deal of expertise and over the next year ***Colorado Medicine*** is going to share that expertise with you.

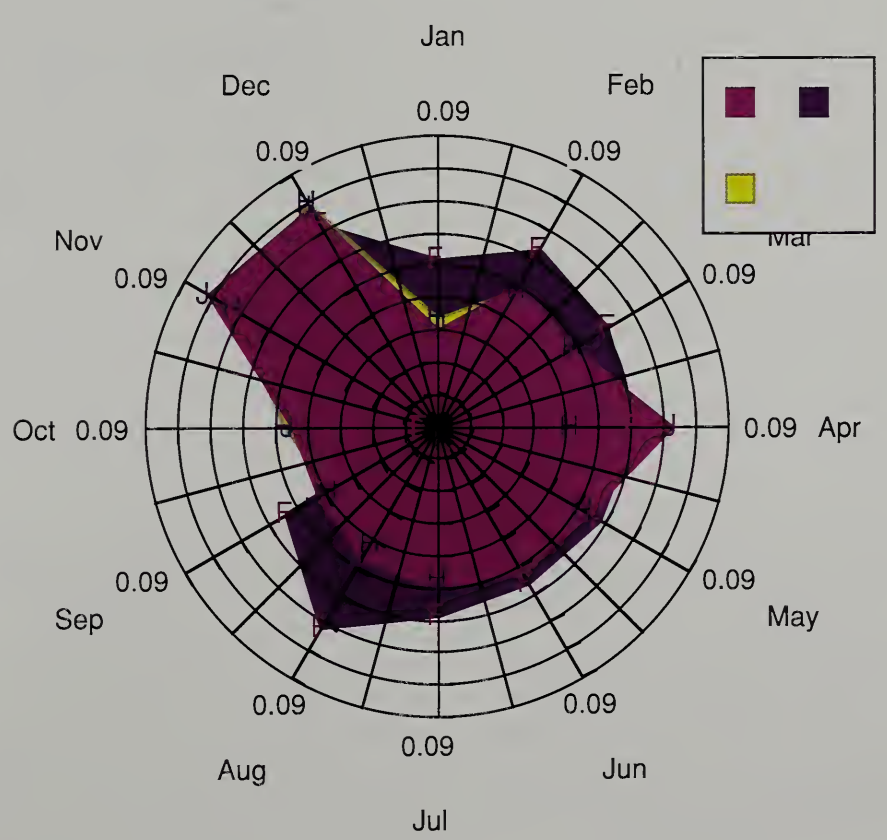
The Colorado Medical Society is involved in accountability because we are advocates for patients and physicians. As patient advocates we must examine what we can do to improve the health care of our patients and our communities. As physician advocates we want to ensure the integrity of health care data and help physicians understand how to use such data.

Because CMS does not have direct access to data and because we have no funding to collect such data, we seek to work cooperatively with others within the health care system. Our role, therefore, is in education, recommendation, collaboration and dissemination.

There are an abundance of data collection efforts, but physicians need help in accessing, interpreting and using the data available to them. If we can't interpret the data, we can't use it to improve the quality of our care. In addition, we need to be using patient satisfaction data to improve health care delivery and the health of our patients. We all need to be doing outcomes and the CMS is going to help you do it.

Over the next twelve months you will be exposed to the expertise of John Steiner, Byron Jones, Gail Whiteneck, Howard Shapiro and others. Ned Calonge gave the keynote address at our accountability conference and it is appropriate that he is the leadoff hitter with his article, ***"Outcomes in clinical practice"***.

How are "outcomes" to be measured?



Outcomes In Clinical Practice

by Ned Calonge, MD
Clinical Epidemiologist
Colorado Kaiser Permanente

Keynote Address—1997 CMS Leadership Conference, Vail, Colorado, May 31-June 1, 1997

"Now, the purchasers of care are saying 'Show me'. . . "

The old paradigm for medical outcomes was simple: trying to decide "who was good at being a physician?" or "who wasn't good at being a physician?" (how about 'who was less good?') It was a very informal process. . . word of mouth by peers and patients was how we knew who had good outcomes. We were in this mode for a long time. Most of we physicians were comfortable in considering the practice of one of our peers as thinking that we knew something about outcomes and quality. Then, the world started to change. Hospital monitoring of quality care began when we started looking at surgical qualifications and infection rate. The birth of the peer review organization came about (i.e., Colorado Foundation for Medical Care) and we had a new level of monitoring. Finally, we started having payers looking at diagnosis and procedure-based utilization as a way to monitor outcomes. In Colorado we had the rare opportunity to enjoy the Health Data Commission for a number of years before the legislature decided that the Commission was not a value-added function of governance.

Things have changed. There is a new paradigm and, for the most part, I don't think that physicians led in creating this new paradigm. I think, instead, that the failure of the national health care reform resulted in a health care reform created by employer demand, by the payers for care in America. So, from employer demand and competition among health plans, we have a new paradigm that's been implemented through managed care. There are a few alphabet items that we have to clarify when we start thinking about this. One is NCQA (the National Council on Quality Assurance), and the other is the HEDIS (Health Plan Employer Data Information Set), and this is generally the operating system and the software for outcomes research and outcomes definition. The reason these bodies were created was to provide information to allow purchasers and consumers of health care services to make judgments regarding value. You won't find this in any medical text book and, in fact, when I talk to medical groups, this subject is the one that usually produces the most consternation and alarm because it says funny things. For instance, we use economic terms and this brings a different reality to the way we practice. We talk about the purchasers of care; we talk about our patients as consumers of health care. And then we talk about value. Value is a new concept. It's not that we can't provide the absolute best health care possible what with all the technologies and all the costs. It's just whether people believe that these things are adding sufficient value for their health care dollars.

So, this is one paradigm shift, and one that I think we have to understand. Another one with which I like to think that we are comfortable is the need to be accountable for the outcomes in medical care.

Let's talk about definitions of outcomes. It's a short word but there's a lot of meat on it; there are a lot of different issues that people look at. Let's talk about the measurement of outcomes; how are people currently doing it. It may not be how you and I would to measure outcomes.

We'll start with "Utilization and Cost", and then discuss things called "Process Outcomes" or "Intermediate Outcomes." These are results that may not be outcomes in themselves, but we believe if we achieve them we improve health down stream. Then there are medical or "downstream" outcomes themselves, and then other categories that we are not accustomed to measuring, one being "Utilization as it affects health status", and the other is "Purchaser or Consumer Satisfaction". Let's talk about these, one at a time.

Utilization and Cost is no new thing to people practicing in Colorado. With 30-40% of Coloradans enrolled in Managed Care plans,

Outcomes In Clinical Practice

(Continued)

most of us have had some experience with this particular "outcome measurement". It may not be our favorite outcome measurement, but it is certainly one that drives a lot of effort. It is divided into these major categories: One description which we all got used to early on was "Hospital Admission" and "Average Length of Stay". As we found ways to keep people out of hospitals and get them out of hospitals quicker, we actually maximized this variant. Then we move into something that is attached to the hospital, which is "Emergency Room Utilization" and "Visits", another expensive source of care, and finally on into "Utilization and Cost of Other Ambulatory Care Visits". So our utilization and cost reviews actually consist of the physicians time and the hospital time.

There are many other categories that we all know are now being looked at as well. There's pharmacy utilization, including what drugs are you using and how often are you using them? Radiology, laboratory, and other kinds of ancillary service utilization, such as expensive, Rapid Sequence CT for Heart Disease. And finally, referral to sub-specialists. Management is pretty straightforward; we're starting to learn what affects them, and I think we're going to continue to see these areas as a part of any outcome study.

What are the "Process Measures", the "Outcome Measures" that aren't quite downstream or aren't quite the actual outcomes of the care? These are such things as preventive medicine services. I know, for example, that mammography can reduce the rate of the risk of dying from breast cancer about 30% in women over 50. So I know I have a preventive procedure that appears to be effective. If I can push the penetration or utilization of that preventive procedure up, I can, without looking, expect a downstream benefit. And so, one of the outcomes we see being used are things like utilization of preventive medicine services.

The next areas of intermediate process outcomes are quality assurance and quality improvement effort. Quality assurance depends on you being able to define quality, and this tends to start falling down in the area of medical care standards...the no-brainers, the things that even leaders in medicine would agree should be done; i.e., if someone is on coumadin, you should check the protime often. So we already have some concept of what we can do in quality assurance and quality improvement. If we move out of standards of care and those things we should always do, we are talking about a guideline for medical care consisting of procedures we should mostly do, then we need to look at other outcomes, such as guidelines compliance and disease management. For instance, how many of my patients who have suffered heart attacks are on beta blockers? I can't make that a standard practice because there's clearly contraindications to beta blockers, but I can say that as a guideline, it is something I should try to adhere to and be in compliance with. So these are kinds of intermediate or process measures.

What about "downstream" measures"? I can always start with undesirable non-disease outcomes because I always look for a category for "unwanted pregnancy". It doesn't seem like it should come under "Planned pregnancies;" it doesn't really fit under "disease", but it is something we would like to not have. We would like to try to push down the rate of these undesirable non-disease outcomes. Another undesirable outcome would be "newly arising diseases", especially if it is a preventable outcome. But clearly, it's an outcome area that I would like to be able to address. And then, there is "changing status of existing disease". I should point out that we can get improvements in disease, but we usually concentrate on worsening disease, complications and the way downstream effects of medical care, or lack thereof, which are death.

Moving away from medical outcomes we, as physicians, have to deal with a new definition of downstream medical outcomes, which is "functional health status." I want to expand on this area because I believe it is new to most physicians. It includes self-reported health status, and the part that the purchasers of health care are interested in, in fact most interested in, is "productivity". Can we show that our medical practice, somehow equates to their bottom line?

The last outcome I will mention, briefly, is the satisfaction of our purchasers and our consumers of care.

How do we measure these things? Cost is pretty simple, so I'm not going to go through those, but let's talk about measuring intermediate outcomes. I mentioned this already: For example, we'll just look at the penetration of clinical preventive services. I'll see how many women over 50 actually have a mammogram on some kind of agreed-upon schedule. How could I do that? In a closed system, like Kaiser, I can measure it directly. Recognizing that Kaiser is only a part of the market, there has to be other alternatives, and what we find is that examining each billing record. Many of you know that "chart audit" is used, or you can use direct patient survey, which is pretty accurate. In fact, is the only way we can get at some issues like whether or not you are actually advising all of your smokers to quit smoking.

You can also do intermediate outcomes by looking at compliance with clinical guidelines. And until automated medical records and shared information systems have more visibility, develop a life of their own and become ubiquitous, we can only check compliance by looking at charts. The only way we know whether or not we as physicians are complying even with our own guidelines is to look at the charts, which are the documentation of the process of care.

What about downstream

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Outcomes In Clinical Practice

(Continued)

outcomes? Well, for the most part in the real world, if you will, or the world outside of Kaiser, we're stuck with using something similar to building codes, and we have to look at what we are actually telling the payer about what we're doing as a way of monitoring worsening or improvement of disease. Most physicians who have ever filled out a superbill can see the trap in that. How accurate is administrative data in actually recording the processes worsening or improvement of care?

We can also look at utilization . . . we're pretty good at this. We can look at admission rates and readmission rates. In theory, you can have a high admission rate for heart failure or asthma, and we can somehow "severity adjust" our practice so that it looks like everyone else's. We would say that maybe you're not doing something you should be doing.

Low birth weight is a downstream result that is easy to measure and ends up showing up in a lot of measurements.

So, health status measures is that functional self-reported health I mentioned earlier. How do you measure self-reported health? What is self-reported health, first of all? Well, it isn't your perception of how well the patient is; it is the patient's perception of how well they are. This measurement requires direct patient survey. Generically, we identify the tools as health-related quality of life, and essentially these have been around for more than twenty years, but outside the research environment none of us really has a great deal of experience with them. So, I want to introduce the concept to you because I think it is a critical new move in terms of judging or being accountable for what we do in practice. There are two major types: "generic", which is usually targeted at specific age groups; and, "health status measures" that are disease-specific. The one measure with which I can nearly guarantee most physicians will have some experience during your practice is the SF-36, which stands for Short Form 36. The "36" relates to the number of questions included. It was developed by Rand in 1983 and the questions cover the multiple health related outcome domain called sub-scales. The SF-36 talks about effective well-being, general health perception, pain, physical function, role limitation and social functioning. So it's designed to look at functional status as part of the primary care visit, and that's really what it was designed to do. It has been used successfully in cases of asthma, angina, hypertension, kidney disease, multiple sclerosis, peptic ulcer disease and diabetes, and in these groups of people it seems to be able to discern between relatively small changes of ill health.

The other interesting thing about SF-36 is that it predicts health care utilization. When I first learned this I was fascinated because it gets back to the maxim: "It's not how you are, it's how you think you are that determines health care utilization". One question, "How is your health? and an accompanying five-point scale, excellent to poor, is the single-most predictive question in the United States for deciding who is going to be a high or low utilizer of health care. And the 12-item subscale, the SM-12, is good to predict utilization for large groups, groups of 1 to 2 thousand, within four percent of actual cost. That's how good self-reported health status is as an outcome measure.

What about the SF-36 in practice? It seems to work pretty well for those of us who have buildups. We are concerned that could be insensitive to big change in health status in people who are already well or highly functioning. The strange part to me is that we really don't know if our clinical interventions change the scale, even in cases otherwise classified as a success. This would be the heart failure patient whom you have tuned so finely that they can walk out of your office; they're not too dry, they're not too wet, and yet they feel awful because of the medical regimen that is required to keep them at that point.

There are, however, better instruments for predicting utilization in some age groups.

So what do we need on the SF-36? We need to know an actual history of this instrument over time. Even though it's been around for a number of years (1983), we don't really know, for instance, in different age and disease status groups what happens to it over time. I can tell you, at least, that in the Kaiser population it goes down in seniors. So as you get older, you get worse. Now we may be able to address parts of that, but we're not yet sure which portions of the SF-36 can be addressable to our direct health care services. It also remains unclear what role or value the SF-36 has in the database of provision of care by physicians and other providers. My question is "as a practicing clinician if you hand me this form, what am I supposed to do with it?" I'm not clear what the answer is.

This is just to let you know that there are disease-specific instruments that really behave better for detecting small but significant differences in the targeted disease.

Patient satisfaction clearly requires direct-patient surveys, and as you have probably all experienced, it seems that every managed-care organization has to have its own, but they all have the same kind of matrix. They all look at aspects of service; that is, "how long did I have to wait in the waiting room?" "How long did I have to wait to get an appointment?" "Were the people in the office nice to me?" "Did I feel respected, like I was listened to?" And then there's the thing called "Perceptions of quality:" "Did the physicians seem to know what they were doing?" Were the patients confident that the physician got to the right diagnosis? These are the two aspects that you usually see in the questionnaire, and the only light I see on the horizon is that NCQA and HEDIS now require a standard measure. They're going to say "We don't like dealing with everyone

Outcomes In Clinical Practice

(Continued)

else's measures, so we're going to make you use ours."

Let me tell you what I think is going to happen with outcome measures over time.

There will be better measures so if you're distraught over what will be described to you during this conference, take heart in the fact that measurement is evolving over time and it's a little bit better with each successive approach. Recognize that we've never tried to measure outcomes on a population basis before. You and I were content when we had a feeling that our patients did get better, and that was our outcome. Now, the purchasers of care are saying "Show me" by saying "I want to see what it is you're doing that is effective, so I know what I'm buying." There can be standardization of measures, which would make our lives a bit easier. Hopefully, we'll get a better approximation of what I would call "Outcomes-based quality of care". We're very, very good at measuring costs of utilization. We need to get a little bit better, both physicians and medical groups, at deciding how we measure the outcomes-based quality of care. Unfortunately, that's going to require more intensive measurement. Probably the bad news of the day is that if you feel any measurement is onerous now, just wait because it's going to get worse. The other thing I would say is that there's a lot of research in outcomes measurement, and you are going to see more articles in the New England Journal and JAMA that talk about effectiveness of care for policies and procedures and guidelines that are applied to a population. In fact, the Medical School and the Dean are putting together an outcomes research center at University of Colorado Health Sciences Center, and I have high hopes that they'll produce some useful information.

How can we change our practices to move away from what we're accustomed to, to effecting outcome measurements? To start with, how do you effect utilization and cost? I believe if we can move to evidence- versus expert-based practice, we're going to see improvements in utilization and cost, and that means "I want to truly know that what I do makes a difference in the person's health and wellness."

I think we have to start out as patient advocates because no one's going to listen to us otherwise. Also, advocates for quality. When these clinical guidelines are being put together, physicians need to be involved.

When I use the term "physician advocate", I'm being very specific, meaning to advocate at the least for making the system as easy on the clinician as possible. It's not to make sure that we all have jobs, or that we all have the incomes that we'd like to have. It's to say "You know, at the very least you guys should get together and say 'what's the outcome I need to measure?' and let's do it the same way on everyone, and then start recording them the same way, so that I know where I stand. I shouldn't have to look at an FHP, Cigna, a PruCare or a Primera list and try to guess how I am doing as a clinician. I should be able to figure that out before I get to deselection."

As a body, we need to take the role of liaison and advocate of quality and patient advocacy with our policymakers at the legislature, before the people who are making decisions about regulation of care, about mandates, about how we're going to practice in the future. Physicians need to be represented at the table at every step. We should not have a health care reform process that goes forward without a physician, or a clinician if you will, directly involved.

The Accountability Committee needs YOU!

As Dr. Gary VanderArk takes the reigns and heads CMS toward greater leadership in accountability, the Accountability Committee is beginning a new project which requires physician participation. As advocates for patients we must examine what we can do to improve the health care of our patients and our communities. As physician advocates we want to ensure the integrity of health care data and help physicians understand how to use these data. To that end, the Accountability Committee (formerly the Data Committee) is developing an outpatient patient satisfaction survey project.

The goal of the project is to begin to assist physicians with improved understanding of how to access, interpret and utilize data available to them.

We would like to put together a working committee of physicians who would be willing to: 1) help design a patient satisfaction survey for outpatient settings, which would provide useful information for physician's; 2) pilot test the survey in their own practice settings; 3) help review and interpret the results of the survey; and 4) help determine effective methods for disseminating the survey tool and pertinent information to CMS members.

There are an abundance of data collection efforts, but physicians are not always afforded the opportunity to learn how to access and interpret these data. If we can't interpret it, we can't use it to improve health care delivery and the health of our patients. Please contact Ellen Stein at the Medical Society offices (303-930-0414 or 1-800-654-5653; or e-mail at Ellen_Stein@cms.org) for further information and to volunteer to participate with this project.

Who's WATCHING OUT For You?

From providers to community leaders, researchers to educators, and government officials to citizens, the National Rural Health Association's members seek to improve the health care of rural Americans through advocacy, communications, education and research.

The National Rural Health Association and its members work to overcome rural health care challenges. They focus on reforming and strengthening health care to meet the needs of rural areas. While government funding continues to dwindle, this multi-disciplinary group of health professionals and leaders finds innovate solutions to complex dilemmas.

NATIONAL RURAL HEALTH ASSOCIATION — *Caring for the Country*

For more information, contact the NRHA,
One West Armour Boulevard, Suite 301, Kansas City, MO 64111;
816-756-3140; fax 816-756-3144.

YOU

THE NUMBER 1 REASON YOUR PATIENTS WILL HAVE A MAMMOGRAM THIS YEAR.

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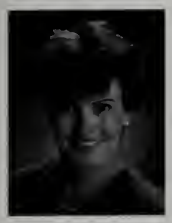
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MAMMOGRAM
EVERY YEAR AFTER 50

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AMERICAN CANCER SOCIETY

Colorado Medical Society Alliance



Stella Shanks, President
Colorado Medical Society Alliance

If battered women shy away from seeking help from the police or social service agencies, they *do* continue to rely on the health care system for treatment. This fact makes physicians' awareness of domestic violence a critical element in efforts to address the epidemic and to estimate its size.

In a report by the Department of Justice this August, the data showed that the occurrences of injuries inflicted by a current or former spouse or boyfriend, is four times greater than previously estimated. Bonnie Campbell, the director of the Justice Department's Office of Violence Against Women, said that the report is proof that domestic violence is seriously under-reported to law enforcement authorities.

These statistics are frightening, but they can be dealt with, one victim at a time, one doctor at a time, one community at a time.

Violence in a community can be likened to the frog in the pot story. If you have a pot of boiling water and you pick up a frog and throw him in, he panics and leaps out. If you have a pot of cool water, turn up the heat, pick up a frog and throw him in, he gradually gets uncomfortable. He doesn't like it very much, but he slowly adjusts...until it is too late. Violence in our community creeps up on us the same way. We get uncomfortable, but we adjust and we endure. What we really need to do is panic, we need to leap into action.

The Colorado Medical Society continues it efforts for the Stop America's Violence Everywhere (SAVE) campaign by educating physicians on how to recognize domestic violence. It is a fact that a physician is usually the first non-family member a victim turn to for help. And while physicians cannot solve the problem of domestic violence, they can diagnose and treat the injuries and offer appropriate referrals. Physicians are part of the solution.

The Medical Alliance, as physicians' spouses, are committed to the SAVE campaign. Throughout Colorado, extra efforts are being made during October to bring awareness to our communities about the problems of violence.

El Paso County has adopted a shelter and has collected donations and supplies specifically for the Children's Center. Metro Denver Alliance and the Colorado Coalition Against Domestic Violence joined forces on October 6 to honor victims and survivors by planting a tree on the grounds of the capitol. Their observance of National Unity Day was a symbol of hope for children. Mesa County Alliance, in coalition with the Woman's Resource Center, held a courthouse vigil. The Mayor, also an Alliance member, read a proclamation and four police officers were awarded the Volunteer of the Year Award for service in preventing domestic violence. Three billboards were purchased which provide much needing information for victims.

Albert Schweitzer said, "It's not enough to say, I'm a good father, I'm a good husband...You must do something for those who have need of help, something for which you get no pay but the privilege of doing it.

"These statistics are frightening, but they can be dealt with, one victim at a time, one doctor at a time, one community at a time."

For remember, you don't live in a world all your own. Your brothers and sisters are here too." So, on behalf of your spouses, I want to thank you for your participation in the SAVE campaign and for your support of our efforts.

Victims don't need to suffer in silence. There is help available.

Moving toward consumer driven health care

by Joel M. Karlin, MD
AMA Delegate



"The three health plans which were rated the highest were the three plans with the most physician input..."

The haze is finally lifting as the "health care train" prepares to leave the station, and consumer passengers in Colorado should be feeling pretty good. A national magazine recently picked Colorado as one of five states which has done the most to help the public sort through the health care haze. Colorado has seen the private sector and state government come together to reassert the rightful, preeminent position of the individual when it comes to health care.

As we move toward a system in which the individual selects the mode of delivery and the health plan which best meet his/her personal needs, our patients need information to make informed choices.

An important piece of that necessary information has been released by the Colorado Business Group on Health. The Group's annual "report card" on Colorado health plans (Figure 1), entitled *Health Matters*, is a comparative compilation of over 11,000 policy holders in nine different health plans, rating each plan according to the following consumer satisfaction parameters: overall satisfaction with their current health plan; attention given to what the patient has to say; ease of choosing a personal physician; how much the patient was helped by the care they received; overall quality of care and service; availability of information about eligibility, covered services, or administrative services; receiving care the patient and their physician believed was necessary; getting a referral to a specialist; willingness to recommend the health plan to family or friends; and intention to switch to a different health plan.

Is it any surprise to learn that the plans which generally received the lowest ratings in *Health Matters* are the plans we physicians also find most difficult with which to work? Would it be a revelation to learn that the three health plans which were rated the highest were the three plans with the most physician input and control of health care policy? Rocky Mountain HMO, Health Network of Colorado Springs and Kaiser Permanente were those leaders.

The clear winner in this survey was Rocky Mountain HMO. This is not the first time Rocky Mountain HMO has been selected to receive such honors. The survey of participants in the Federal Employees Benefits Programs traditionally rates Rocky Mountain HMO at the top in consumer satisfaction. Is there any wonder why Colorado Physicians' Network (CPN), the second birth-child of the Colorado Medical Society (CMS), selected Rocky Mountain HMO as their strategic HMO partner?

As a member of the CPN Board of Directors, I can only begin to share with you the excitement our Board feels as we develop the "next generation" of managed care. This collaborative effort brings primary care and specialty physicians together to provide a continuum of accountable, high quality care to that entity around whom *our* system has been created, the *patient!* As Rocky Mountain Physicians' Choice (RMPC), the health plan of CPN and Rocky Mountain HMO, is intro-

(Continued next page)

duced in the front range, both patients and physicians will delight in the patient focused systems which will differentiate RMPC from competitors.

The second piece of useful consumer information will be made available by the state of Colorado in January, 1998. This framework for comparative health plan disclosure is the product of diligent work by patient advocacy, consumer and employer groups, along with CMS and representatives of the health insurance industry. Mandated by HB 1311, the Colorado Division of Insurance, ably led by Jack Ehnes and Barbara Yondorf, has promulgated regulations on the format and content of the disclosure form. Soon your patients will be able to use this simple disclosure form to do line by line comparisons of all Colorado health plans. Information will include; benefits and exclusions; deductibles and copays; lifetime maximum benefits; out-of-network coverage; pre-existing illness limitations; preauthorization requirements for referrals, surgery and hospital care; grievance contacts; physician network issues; physician reimbursement; physician financial incentives; and medical care loss ratios. CMS is currently assessing a project which will use this disclosure information to assist patients with their health plan selection.

At the same time, our AMA is moving forward to fashion an action plan which will give patients the right to select and own their health insurance plans. This legislative package, scheduled to be presented during the second half of 1998, is being formulated by subcommittees of the AMA Council on Medical Services, chaired by Dr. Susan Adelman of Michigan, and the AMA Council on Legislation, chaired by me.

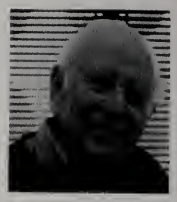
It is through these actions that the information deficient haze of health care is being lifted. Organized medicine continues to be the engine that helps diffuse that haze... So hold on tightly. The train has left the station and the destination is in sight, a consumer driven health care system is just around the bend!

HMO Report Card

★ lower than most Colorado health plans
★★ similar to most Colorado health plans
★★★ higher than most Colorado health plans

	Antero HMO	CIGNA HealthCare	Health Network of CO Spgs	HMO Colorado	Kaiser Permanente	Pacificare (formerly FHP)	Prudential HealthCare	QualMed Plans	Rocky Mountain HMO
1. Overall satisfaction with your current health plan	★	★	★★★	★	★★★	★★	★★	★	★★★
2. Attention given to what you have to say	★★	★	★★	★★	★★	★★★	★★	★★	★★★
3. Ease of choosing a personal physician	★★	★	★★	★	★★	★★★	★	★★	★★★
4. How much were you helped by the care you received	★★★	★	★★	★★	★	★★	★★	★★	★★★
5. Overall quality of care and services	★★	★	★★	★★	★	★★★	★★	★★	★★★
6. Availability of information about eligibility, covered services or administrative issues	★	★	★★★	★	★★★	★★	★	★★	★★★
7. Receiving care you and your doctor believed was necessary	★	★★	★★★	★	★★★	★★	★★	★	★★★
8. Getting a referral to a specialist	★	★	★★★	★	★★★	★★	★	★	★★★
9. Willing to recommend health plan to family or friends	★	★	★★★	★	★★★	★★	★	★★	★★
10. Intention to switch to a different health plan (*** means don't intend to switch)	★	★	★★★	★	★★★	★★	★	★★	★★★

Source: *Denver Post*, September 30, 1997. Colorado Business Group on Health



by John Lightburn, MD
Historian
Colorado Medical Society

This month we welcome back Seymour Wheelock, MD, as guest Archivist for an engaging story about early Denver medicine. John Lightburn

"An Evening with a Pioneer Denver Physician John Elsner, M.D., 1908"

by Seymour E. Wheelock, M.D., Clinical Professor of Pediatrics - Emeritus - Children's Hospital and UCHSC

After what must have been a stupefying annual dinner of terrapin soup, oysters Rockefeller, cordon bleu or beef Wellington, salad, ices and three choices of wines, the Staff and Board of Managers of the National Jewish Hospital for Consumptives settled comfortably in their chairs to hear the honored speaker of the evening. The room quickly filled with the fragrant blue haze from fifty cent after-dinner cigars: Floradora, Grand Republic, La Toca Cuban and Grand National, among others.

At a congenial table of three physicians, Dr. Emmanuel Friedman, recently come to Denver, leaned over to inquire: "Just who *is* Dr. John Elsner?"

Dr. Robert Levy whispered the information: "He's an old-timer; he'll tell us about it, I'm sure. Came to Denver right after the Civil War looking for mineral riches, like so many. He replaced old Dr. Hamilton as city physician in 1870 - even rented a building, spent $250 equipping it and, they say, went about with a wagon collecting patients from hen houses and barns. Can you believe it? When the new combined poorhouse and hospital was built in '73, Elsner stepped down, and I don't blame him."

"- and remember," Dr. Moses Collins, Medical Superintendent and 3rd member of the group added, "He and Fred Bancroft - remember Bancroft? - giant of a man - carried a six shooter - organized the Denver Medical Association along with nine others, in addition to the County Hospital business. Those were busy days. I remember Elsner telling us once that in the first 20 years of his practice he had seen 400 cases of diphtheria."

"My wife's mother knew the Elsners well" said Dr. Simon, expansively, blowing a cloud of smoke. "She found their house so full of rare books and porcelains, antiques and paintings by artists I never heard of that she could scarcely move around. Interesting couple - even had Oscar Wilde to dinner once."

Conversation gradually diminished and then ceased as the president of the Board, Rabbi William Friedman - slender, energetic and soft spoken - tapped spoon against glass.

"We are fortunate here, eight years past the turn of the century to have as our speaker, Dr. John Elsner. Most of you know him; if not, you surely know *about* him. He has told me he plans to speak of those early years in Denver medicine - years and events in which he played many roles, so further introduction is unnecessary."



John Elsner, MD

It was somewhat difficult for those diners in the rear of the crowded room to see Dr. Elsner through the drifting blue haze, but his voice, somewhat high-pitched, carried well as he drew with a deft verbal brush a colorful, intimate portrait of his life as a young and ambitious physician in a Denver, and at a time, most of his audience knew only second-hand.

"Members of the Staff and Board of Managers" he began, warming quickly to his work. "Not having been well for the past few months, I thought it best, instead of giving this off-hand, to jot down a few of the events which transpired that might possibly be of interest for you to know.

"Your kind invitation reminded me of the fact that I am the only practicing physician living in Colorado of those who came before me or at the time I did, and it at once carried me back over 40 years to the close of the Civil War when I left New York to cast my lot in the 'Far West.'

"I was financially interested along with others, in a mine in Central City called the 'Onondaga', so I traveled to Waterloo, Iowa where I was immediately elected captain of the train which consisted of 27 covered wagons, 35 men, 14 women and a number of children whose welfare deeply concerned me.

"We took along a certain amount of mining machinery as the majority of the men were to work this property. We averaged 24 to 26 miles a day, had a number of brisk encounter with the Indians, and were compelled to circle our wagons at night before dark and station picket guards a short distance from the wagons to protect ourselves, the women and the children from unexpected attack.

"I owned half interest in a wagon but I rode horseback or walked the 40 days it took to reach Denver, arriving June 6, 1866. There were about 17,000 people and a military post, commanded by Colonel Howard. On the right side of Blake Street, between Fourteenth and Fifteenth Streets, the sidewalk was covered with tables where they carried on open gambling games of all kinds conducted by some of the most noted gamblers known to the region.

"The center of Blake was crowded with ox trains and bull whackers coming in with freight of all kinds. These bull whackers, having been three to four months on the plains, were paid off here and as long as the money lasted (and their watches and revolvers), would proceed to lose everything, often on a single card.

(Dr. Elsner then named the four or five other physicians who practiced in Denver in those unsanitary, exuberant days, particularly a Dr. McClain who was a military surgeon and who died of blood poisoning caused by a cut received from a penknife while opening a nut.) "It found necessary to amputate the hand, in a short time the arm, whereupon death intervened."

"In 1868," he continued, "I performed what I believe to be the first operation for stone in the bladder upon Judge Perkins.

"The anesthetic was administered by Dr. Heimberger, now living in Denver. The operation was successful and the judge lived five years afterward, dying as a result of an accident, having fallen into an excavation one dark night in Golden.

"I performed a second operation for stone about three months afterward near the Cimmaron Mines on Mr. Maxwell, of Maxwell's grant[1]. The government furnished me an ambulance and a squad of soldiers who escorted me there and back. The anesthetic was given by a distant relative of Mr. Maxwell's from St. Louis.

"Not long after this I received a call from Mr. Stabe in Santa Fe. The trip was made by coach and it took 5 days. Inside the coach were eight passengers - seven men and one woman, one of them General Charles Adams. One morning during our trip the General took from his pocket a pipe and a match and turning to the lady beside him said, 'Madam, is smoking offensive to you?' She said, 'Indeed it is.' He thereupon lit the match and with it the tobacco in his pipe and answered, 'I am *very* sorry.'



Lucien Bonaparte Maxwell

"We changed our horses about every 20 miles and one evening arrived at a place called the Red Lion Inn. Our room was on the first floor and our ceiling the starry heavens, the floor Mother Earth. The door was an army blanket and on the small board table was a tin candlestick holding a candle about one-half inch long. The bed was such that Judge Kingsley and I decided not to go to bed but sat on it amusing ourselves by telling stories all night.

"The next morning we were called to breakfast, and found in the breakfast room a long table covered with oilcloth, benches on both sides, tin plates and the knives and forks chained to the table, and in a short time a man wearing a slouch hat and short coat, his trousers held up by a belt holding a revolver, entered, carrying a large wash basin, which I learned contained hash. He dumped the basin on the table, took out his revolver, and with it in his hand looked all the passengers in the

(Continued next page)

[1] When Dr. Elsner removed the stone from the bladder of Lucien Bonaparte Maxwell, he probably didn't know he had operated on one of richest men in New Mexico, whose income from the "Cimmaron Mines" and other interests amounted to a staggering $50,000 a year. Maxwell often kept $30,000 in gold, silver and greenbacks in the bottom drawer of an old pine bureau in his home in Cimarron, New Mexico, a small town south-west of Raton, N.M., at the mouth of the Cimarron River. One wonders what type of ambulance jounced over plains, past Huerfano Butte and over Raton Pass for over 500 miles.

Archives *(Continued)*

eye, saying, with an oath: 'Perhaps there is someone here who is not fond of hash!' There was not a passenger who didn't seem to think that he had always loved it. That was the last time I ever ate hash.

"We finally arrived in Santa Fe, stopped at the Du Fonde only one day, when Mr. Stabe kindly removed me to his house, where I had the best accommodations.

"On my return to Denver, I learned of the Indians outrages on the Bijou, where a man by the name of Lindsay was accidentally shot. He was going to visit one of his friends, and instead of knocking at the door, said, 'How,' and his friend, believing him to be an Indian, fired through the door. The bullet passed through the upper portion of the left lung and lodged in the back under the scapula. A telegram was sent to Mayor De Lano, then mayor of Denver, to send someone to remove the bullet and attend the man. I accepted the offer, and, with a guide, rode horseback, changing horses every ten miles, being compelled to ride around the Indian camps at night, and was successful in bringing back the bullet and was fortunate enough to save my man and come home safe.

"When I first came to Colorado someone was shot almost every night; many were killed outright. It gave opportunity for many gunshot wounds to be treated.

"On my arrival in Denver, among other things I had a silk hat and an umbrella, and after twenty-four hours I found a placard on my door, with a skull and crossbones at the top and underneath was printed, 'Dispose of your hat and umbrella, as it is a violation of the Vigilantes.' It was not necessary for me to do this, as the following day I missed my umbrella and discovered my hat cut into two parts. From that time on I wore a felt hat.

"In 1871, I called a meeting at my house of the medical men in Denver, extended to them a banquet and then and there organized the first Medical Societies, both City and State. At that meeting also was organized the nucleus of the first Medical College, a county hospital having been established somewhat earlier."

After sauntering about for an hour in the attic of his memory, Dr. Elsner concluded his genial reminiscences[2] with a tribute to the hospital, its management and staff and its valuable place in the community. His closing words were a warm commendation to Rabbi Friedman with whom he had worked 18 years before in the infant beginnings of the splendid institution we now know as the National Jewish Medical and Research Center.

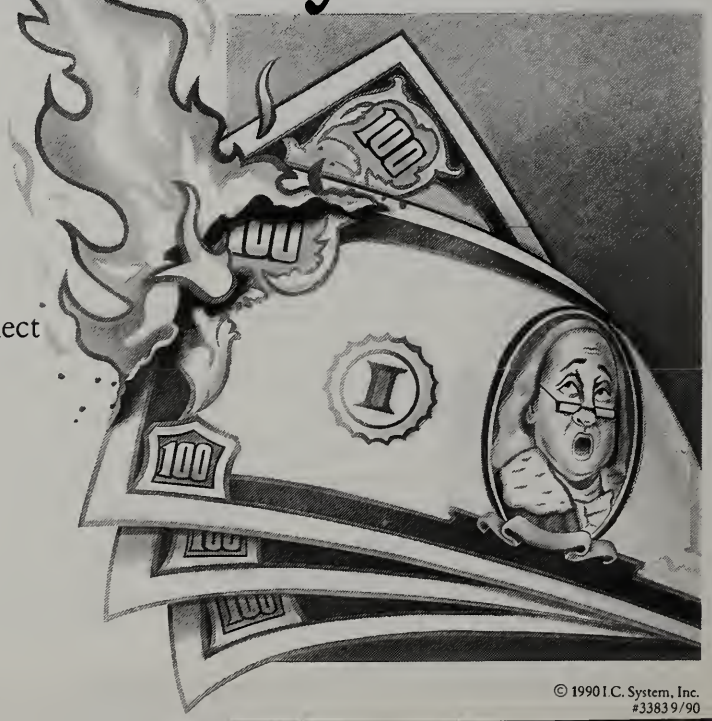
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[2] "Reminisces" Elsner, John, M.D. published in Colorado Medicine Vol. XXVIII No. 1 July 1908 (9 pages).

• "Rocky Mountain Medicine" Shikes, Robert, M.D. -(various facts from various pages).

• Dr. Elsner died in 1922, possibly in his home at 14th and Curtis. According to longtime Denver resident, William Wilbur, the home was razed but not the carriage house where his daughter Rose lived. She used the space nearby as a parking lot for cars whose occupants were attending functions in the Auditorium, extracting what sums she could from the drivers, who must have been puzzled by one of Denver's early "bag ladies."

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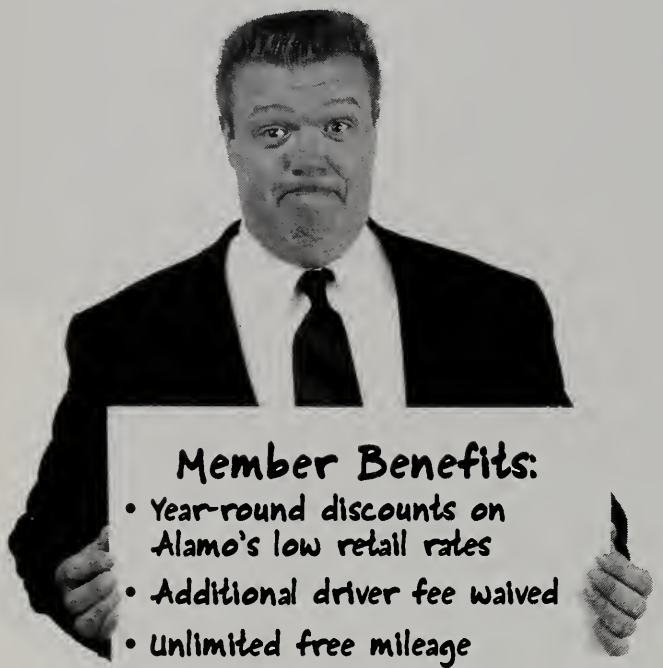
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CopicComment

by Jerome M. Buckley, MD
Chairman & CEO
Copic Insurance Company



Answers to Your Questions About *"Copic Care"*

Copic Care is the long-term care coverage that was added to Copic's medical professional liability insurance (PLI) policy effective September 1, 1997. In this article, I will answer some of the most frequently-asked questions Copic has received since the program's launch. If your question isn't answered here, your Underwriter will be happy to assist you.

Q. I'm not currently eligible for Copic Care. How do I become eligible?

Copic Care is available to full-time physician policyholders and to part-time physician policyholders who have been insured with Copic for at least three consecutive years. Certain policyholders are not eligible; they include slot and locum tenens physicians, physicians in the Retired Physician Program, and part-time physicians who have been insured with Copic for less than three consecutive years. If you are part-time, you will become eligible for Copic Care on your first annual PLI renewal date following the attainment of three consecutive years of Copic coverage.

Q. Can I decline coverage under Copic Care?

Your coverage under Copic Care is incorporated as Section 17.2 of your Copic PLI policy. Just as you cannot decline any other policy provision, you cannot decline coverage under Copic Care. If you already have long-term care coverage, the professionals at Copic Financial Service Group can help you determine your best options for maintaining, changing, or dropping your other long-term care coverage.

Q. How can I enhance my Copic Care coverage?

In the near future, you will be able to choose from a number of options for enhancing your Copic Care coverage. These will include:

- Increasing the amount of your daily benefit (currently $100 a day)
- Increasing the duration of your benefit (currently 365 days)
- Sharing your benefits with your spouse
- Obtaining coverage for your family members and/or employees

We anticipate that these enhancements will be available beginning December 1, 1997. In the meantime, you can call Copic Financial Service Group (CFSG) with your questions. They can discuss your options and provide an immediate informational premium quote. (Note: all enhancements will be subject to medical underwriting, with no guarantee of issue or renewal.) You can reach CFSG at (303) 930-0493 or (800) 421-1834, ext. 2493.

Q. What happens to my Copic Care coverage if I leave Copic?

If you leave Copic for another carrier, you may continue your Copic Care coverage as a direct payment subscriber. You must pay the premium within 30 days of termination. You will be responsible for making all premium payments. Your "base plan" Copic Care coverage will be paid up after ten years from the Certificate Date on your Schedule of Benefits or when you reach age 60, whichever comes later. (Note: Premiums for enhancements are lifetime-pay.)

If you leave Copic because of retirement or total and permanent disability, your "base plan" Copic Care coverage will be considered paid up provided you qualify for free tail coverage under Copic's Death, Disability, and Retirement (DD&R) provisions (see Section 13.6 of your PLI Policy for details). Premiums for enhancements are lifetime-pay. If you do not qualify for free tail coverage under the DD&R provisions, you may continue your Copic Care coverage in the same manner as a physician who leaves Copic for another carrier (see explanation above).

Q. Does coverage under Copic Care result in any tax consequences to me?

To the best of our knowledge, there is no tax consequence to you as a result of participating in the "base plan" coverage provided as part of your PLI policy. Any premium that you pay for enhancements or as a direct payment subscriber after leaving Copic will be deductible as a medical expense if you itemize, subject to IRS limitations. Any benefits you receive from Copic Care (i.e., any payment of charges for qualified long-term care services) are exempt from federal taxation, subject to IRS limitations. Copic encourages physicians to seek professional advice regarding tax-related issues.

Policyholders Service VP leaves Copic Insurance



Mary Celi Hedin
Vice President
Copic Inurance Co.

Mary Celi Hedin, Vice President of Policyholders Service and Underwriting for Copic Insurance Company, will leave the company effective October 31, 1997. Ms. Hedin joined the Colorado Medical Society staff in April, 1982, to head the Underwriting Department of the fledgling Copic Trust, which was just being assembled. She was the second employee of the then-embryonic physician-owned professional liability trust.

Larry W. Thrower, President of Copic Insurance Company, reflected on Ms. Hedin's 15+ years with CMS and Copic:

"When I arrived at Copic in 1983, I met Copic's first employees, Pat (Crow) Schultz and Mary (Celi) Hedin. These dedicated young women set the standard for future employees. Now, Mary has decided to spread her wings, continue her education and experience new business ventures. When heading Policyholders Service and Underwriting as Vice-President, she somehow found time to design products, organize systems, get married, become nationally known in the professional liability field, earn her MBA and, most importantly, served the physicians in Colorado in a selfless and dedicated manner.



Larry W. Thrower
President
Copic Insurance Co.

In business you hope to encounter someone like Mary and do everything to keep her around. It may seem odd then to feel happy to tell her goodbye when you've depended on her for so much. However, seeing someone blossom and grow and move on and up is the greatest compliment to a manager. We will miss her greatly but feel proud of her past and future successes.

Matthew 25;21 says it well: 'Well done good and faithful servant.'"

Mary has joined a national insurance underwriting company to expand her business experience and increase her "upward mobility". When reflecting on her career path at Copic, she said, "When I left Warren & Sommer (where she was a principal insurance administrator) it was taking a big chance going with an organization that was still formulating a plan, but it was a remarkable opportunity. We came to Copic (CMS) knowing that WE were going to make the rules; it was a chance to make a difference in the professional liability field. I have no regrets, and I leave knowing that the physicians of Colorado are very grateful for what Copic has done for them".

Patricia Schultz, Assistant Vice President, Management Advisory Services, reflected on the first moments when she came to CMS to establish the Trust:

"When I think about those first days, I remember that I needed help; looking at building a file system, anticipating some of the things we were going to go through, and how to develop the program. It was frightening, but it was a challenge. Immediately I thought of Mary. She was a great technician and very organized."



Patricia A. Schultz
Ass't. Vice President

"Probably the most exciting time in those early years was when we issued the first policy. People from our consulting firm were supposed to be helping us put together those first policies, but if we had waited on them we'd still be assembling the policies, so Mary and I just plunged in, got them done and got them out."

"Mary will do well at whatever she tackles, and I'm proud and pleased with what we did in helping build what is now Copic Insurance Company".

Dr. Mark Levine elected president of CFMC

Mark A. Levine, MD, was recently elected to serve as president of the Colorado Foundation for Medical Care (CFMC). As president, Dr. Levine will chair the CFMC board of directors. His term of office will continue until October, 1998.

The Colorado Foundation for Medical Care is a recognized leader in the field of quality improvement. The non-profit organization specializes in utilization review, quality review, and health care management programs. It serves the federal Health Care Financing Administration as the Peer Review Organization overseeing and improving the quality of the Medicare program in Colorado. CFMC was founded in 1970 to work in cooperation with private businesses, the federal government, state agencies, local municipalities, commercial insurance companies and HMOs.

Alert issued over allergic reactions to natural rubber latex

The National Institute for Occupational Safety and Health (NIOSH) has issued an alert to help prevent allergic reactions to natural rubber latex among workers who use gloves and other products containing latex. Latex gloves have proved effective in preventing transmission of many infectious diseases to health care workers. Bur for some workers, exposures to latex may result in skin rashes; hives; flushing; itching; nasal, eye or sinus symptoms; asthma; and (rarely) shock. Reports of such allergic reactions to latex have increased in recent years -- especially among health care workers.

At present, scientific data are incomplete regarding the natural history of latex allergy. Also, improvements are needed in methods used to measure proteins causing latex allergy. This alert presents the following NIOSH recommendations for minimizing latex-related health problems in workers while protecting them from infectious materials:

1) Use nonlatex gloves for activities that are not likely to involve contact with infectious materials.
2) If you choose latex gloves, use powder-free gloves with reduced protein content.
3) When wearing latex gloves, do not use oil-based hand creams or lotions (which can cause glove deterioration) unless they have been shown to reduce latex-related problems while maintaining barrier protection.
4) Frequently clean work areas containing latex.
5) Frequently change ventilation and vacuum filters in latex work areas.
6) Learn to recognize latex allergy symptoms.
7) If symptoms develop, avoid further contact with latex until you can consult a physician.
8) If you have latex allergy: avoid contact with latex products, avoid areas where latex powder may be inhaled, tell others about your allergy and wear a medical alert bracelet.

Please present this information to your employees.

Gatewood Milligan, MD, receives Wyeth-Ayerst Award for Community Service

Gatewood Milligan, MD, is this year's recipient of the prestigious Wyeth-Ayerst Award for Community Service. The award is presented to physicians that demonstrate a strong commitment to the community above and beyond the practice of medicine.



Dr. Milligan receives the award along with his wife Maxine.

A former president of the Colorado Medical Society, Dr. Milligan is also a past president of the Englewood Rotary Club and has played active roles in the Englewood City Planning Committee and the Englewood City Council. He is a former Chairman of the Board of the Englewood Methodist Church, member of the Colorado Commission on Aging and was a member of many other civic and community committees of which few records were kept.

Dr. Milligan's service epitomizes the intent of the Wyeth-Ayerst Award.

by Marilyn Rissmiller,
CMS Health Care Financing Dept.

Use of Private Contracts by Medicare Beneficiaries

...a signed affidavit providing that the physician will not submit any Medicare claim for a two year period.

It has been the position of the Health Care Financing Administration (HCFA) that physicians were required to submit all claims for covered services provided to their Medicare patients, that any private contracts with Medicare beneficiaries were prohibited, and that physicians entering into such contracts could be subject to civil monetary penalties and exclusion from Medicare. However, with the enactment of the Balanced Budget Act, there is now a provision that will allow physicians to enter into a private contract with a Medicare beneficiary for health services providing the conditions noted below are met. **And**, provided the physician is willing to forgo receiving any reimbursement from Medicare for other patients for a period of two years.

When this provision was introduced, the intent was to open the way for private contracting between the physician and the patient without jeopardizing the remainder of the physician's Medicare practice. Unfortunately the budget reconciliation process transformed this provision into one that few physicians will be able to utilize. There is currently a bill in both the Senate and the House that would remove the two year restriction. This bill is expected to face opposition from the Administration and senior groups.

Please note, the private contracting provision in no way affects a physician's ability to bill the patient for coinsurance and deductible amounts, charges for services not covered by Medicare, or charges for services that Medicare considers to be "not reasonable and necessary" (providing the physician has had the patient sign a waiver of liability form). These are all charges that the physician has always been able to collect from the patient and still can.

Private contracting conditions:

- The contract must provide specified beneficiary protections, and be signed by the beneficiary before any services are provided. (It cannot be entered into at a time when the patient is facing an emergency or urgent health care situation.)
- The contract must inform the beneficiaries that by signing the contract they: (1) agree not submit a claim for services even if the services were otherwise covered under Medicare; (2) agree to be responsible, whether through insurance or otherwise, for payment and understand that no Medicare reimbursement will be provided; (3) acknowledge that Medicare limiting charge limits do not apply; (4) acknowledge that Medigap plans do not, and other supplemental insurance plans may elect not to, make payments for such items and services; and (5) acknowledge that they have the right to have such items or services provided by other physicians for whom Medicare payment would be made.
- The contract must indicate if the physician is excluded from participation in the Medicare program.
- The physician must submit a signed affidavit to the Health and Human Services Secretary providing that the physician will not submit any Medicare claim for any item or service provided to a Medicare beneficiary (and will not receive any reimbursement for any such item or service, fee for service or capitated) for a two year period beginning on the date the affidavit is signed. A copy of the affidavit must be filed within 10 days after the first contract is entered into.

Once the final regulations have been drafted more information should be available. If you have any questions, please contact Marilyn Rissmiller in the Health Care Financing Department at 779-5455 or 1-800-654-5653, ext. 2428.

RUMINATIONS

Bill Pierson, ruminator, has been on vacation in October. His column will return in December.

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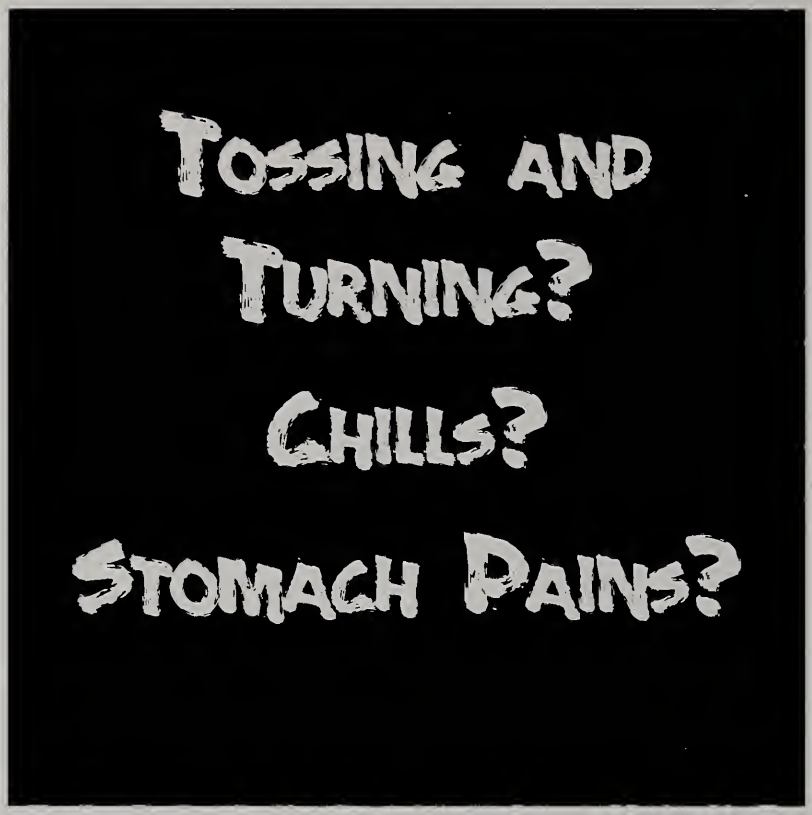
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+ **TO BE ACCOUNTABLE****

In This Issue:

The future of medicine-CMS President Gary D. VanderArk, MD.....**page 437**
Special Offer: "Making A Difference" Summary on Domestic Violence.....**page 450**
Cancer clinical trials by Peter Raich, MD.....**page 442**
Trail Blazer-Josiah N. Hall, MD: "Archives" by John Lightburn, MD.....**page 460**



You must not be insured by Copic.

In an environment of seemingly incessant change, it's natural to wonder — can my insurance carrier keep up? When you're insured with Copic, you can be certain the answer is "Yes!"

— Credentialing is becoming increasingly important for our insureds; that's why we purchased a national credentials verification company and are developing methods to streamline this often tedious process.

— Every day, our insureds are finding themselves in new business relationships with new insurance needs; that's why we created our Medical Entity, Hospital, and Provider Stop Loss policies.

— The legislature can play a tremendous role in health care changes; that's why we focus so strongly on our advocacy and lobbying role.

Copic...keeping up with the changes that affect Colorado health care.

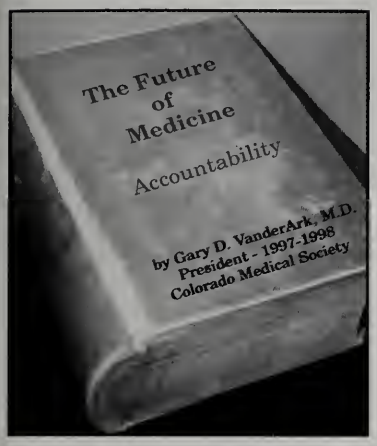
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COLORADO MEDICINE

December, 1997 Volume 94, Number 12



Cover Story

This month we look back at last year and look forward to next year. CMS has been and must continue to be "accountable".
See pages 437, 448-449.

Departments

437 President's Letter
439 Executive Director's Update
440 The Lobby
443 Colorado Physician Network
444 Membership
445 New Members
452 Accountability
454 Health Care Financing
460 Archives
462 Colorado Medical Society Alliance
463 Medical News
464 Classified Advertising
466 Ruminations

In This Issue...

437 **Recurrent themes, predictions and aspirations** – only the common efforts of doctors and patients, medicine and society can shape healthcare's future. Accountability is the glue that binds them together.
Gary D. VanderArk, MD
President, Colorado Medical Society

442 **Cancer clinical trials task force** – new cancer treatment approaches, investigational agents, prevention and control strategies are now accessible.
Peter C. Raich, MD

448 **In their words** – reflections on 1997 and predictions on 1998. CMS leadership speaks out on the role of Colorado's organized medicine.

450 **Domestic violence** – did we make a difference? Throughout the past year CMS has highlighted the signs, symbols and consequences of domestic violence. The "Don't Suffer in Silence" campaign was effective, but the message must continue, and it must include physicians.

452 **Accountability** – A statistician analyzes the validity and interpretation of outcomes studies.
Howard Shapiro, Ph.D.

454 **Highlights of the year end coding/payment changes**

456 **Careful antibiotic use in Colorado** – use of antibiotics has become an issue over the past few years. Why? Part one of a three part series.
Steven Lowenstein, MD, and Kenneth Gershman, MD

458 **The voice of CMS** - place a face with a voice and meet the person who answers your questions.

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Gary D. VanderArk, MD
President, 1997-1998

It seems as though everyone wants to tell us about the future of health care in the United States. Recurrent themes by all of these prophets emphasize the "C" words – competition, consumerism, consolidation and computerization.

If predictions about the manpower glut in medicine are correct, then increased competition is inevitable. That's OK. We are good at competing. That is how the brightest and best became doctors in the beginning. The answer to increased competition is **accountability.**

We're told that consumers are going to take charge of their health care. As our patients become more informed, they will be able to make better choices. I applaud this trend too. **Accountability** will help them make correct choices.

We've already been through consolidation here in Colorado. Will anything of value come out of it? I think the big positive effect will be to enhance our ability to be **accountable.**

Computerization of health care is also a trend that has been going on for some time. It obviously will continue and take health care to a new level. Computerization enhances **accountability.**

What about all the other "C" words that futurists are not touting? How about the "C" words that physicians think are important like commitment, caring, compassion, competency, communication, collaboration and community? Those are the values important to physicians and the thing that will enhance our ability to provide them is **accountability.**

I don't think that we can look to the future without looking at medicine's goals and aspirations. As a result, I'm very grateful for the Hastings Center Report that you have all received this year. I hope you read the whole report which was the product of representatives from fourteen countries. This group says that medicine should have the following four goals:

1) The prevention of disease and injury, and promotion and maintenance of health;
2) The relief of pain and suffering caused by maladies;
3) The care and cure of those with a malady, and the care of those who cannot be cured;
4) The avoidance of premature death and the pursuit of a peaceful death.

Having determined medicine's goals, the Hastings Center Report then looks to the future by listing the aspirations of medicine as follows:

1) To be honorable and to direct its own professional life;
2) To be temperate and prudent;
3) To be affordable and economically sustainable;
4) To be just and equitable;
5) To respect human choices and dignity.

Only the common efforts of doctors and patients, medicine and society can shape medicine's future. How can we accomplish our goals and achieve our aspirations? **Accountability** is the answer.

Do you think that I might be hung up on accountability?

"...that's how the brightest and best became doctors."

LEGAL UPDATE

from Gelt, Fleishman & Sterling P.C.



A. Craig Fleishman, Managing Director

Employment Law Update

The area of the law most fraught with liability exposure on the part of employers today is employment law. Employers are facing lawsuits stemming from (1) inappropriate questions during the interviewing process, (2) refusal to hire and/or accommodate Americans with disabilities in violation of the Americans With Disabilities Act, (3) their permitting sexual harassment on the part of employees against coworkers or facing liability and damage exposure by the very managerial employees perpetrating sexual harassment upon employees, (4) wrongful termination of employees, and (5) violation of various state and federal laws dealing with discriminatory hiring or employment practices and procedures.

It is critical that employers be mindful of the need to evaluate the circumstances under which they contemplate terminating the employment of one of their employees. Has the employee been treated the same as other employees with regard to warnings, discipline, and discharge when the employee is one who is in a so-called "protected" group or class based on race, color, creed, religion, or sexual orientation? Is the employee an "at will" employee or an employee who is entitled to protection under an employee policy manual or formal contract of employment? In any event, even under circumstances where an "at will" employee is involved, does the employee have a defense against termination where the discharge would be in violation of public policy, would be as a result of the employee refusing to engage in an illegal activity, or where the employee is truly being terminated because of a discriminatory practice on the part of the employer? A well-drafted employee manual setting forth appropriate standards of conduct for employees and defining the employee-employer relationship will go a long way towards limiting wrongful discharge claims. In addition, seminars for managerial personnel and for employees are often quite beneficial in educating individuals concerning appropriate behavior towards their supervisors, peers, and those for whom they have supervisory responsibility.

For further information please contact:

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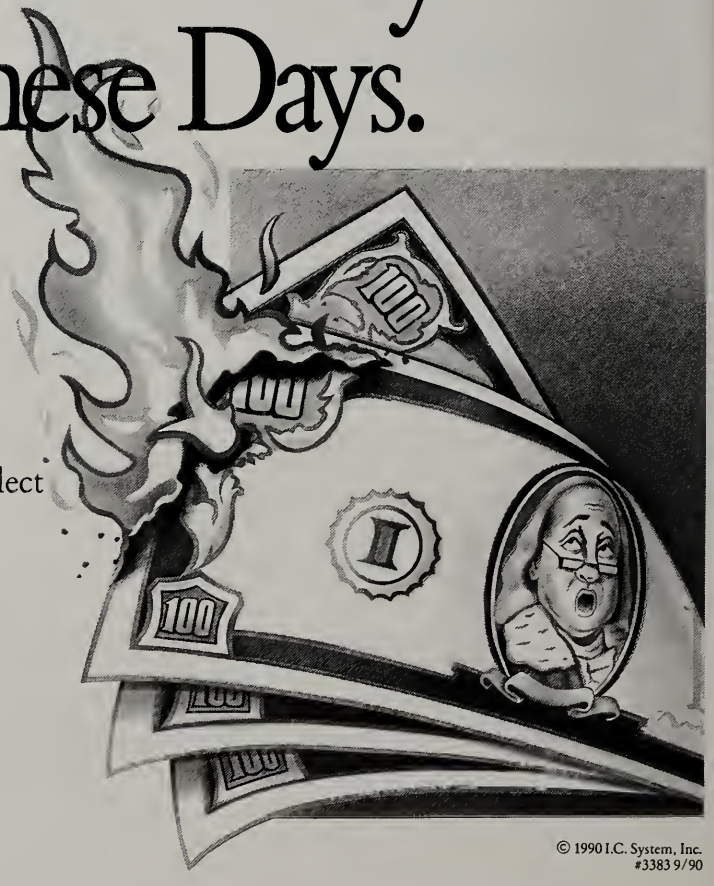
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...a compilation of medically-related news briefs of immediate interest to the physician community occurring after ***COLORADO MEDICINE*** has gone to press. ***AT PRESS TIME...***

CMS Med Fax®
by Montgomery Little and McGrew, P.C.
legal counsel to the Colorado Medical Society

Help is on the way for solving problems between doctors and third party payers

At their meeting on November 21, 1997, the CMS Board of Directors approved a project submitted by the CMS Health Care Financing Department to further assist CMS member physicians.

The project expands the department's current activities, which have focused on timeliness of processing, to encompass a wider variety of the problems faced by physicians' offices when dealing with third party payers. CMS staff will be gathering specific information on the "hassles" associated with late/delayed payment of claims. CMS staff will analyze this information and assist the physicians' offices to resolve problems.

Success of this project will depend on the willingness of the physician and his/her office staff to submit the necessary documentation to the CMS. If successful, this project will identify the source of various problems and allow CMS to take appropriate action. Some of these actions may include:

- Establishment of regular meetings with various carriers to discuss problems;
- Seeking opinions from CMS Managed Care Task Force and/or the CMS/CHMOA Joint Committee, as well as the CMS consultant, depending upon the issue;
- Development of a bimonthly newsletter for physicians' offices to provide feedback and summarize problems;
- Semi-annual meetings with physician office staff, in staffed component societies; and
- Annual quantitative analysis based on data received.

The Health Care Financing Department will be contacting physicians' offices with more information, as the project develops.

CMS Board extends CROP line of credit

On November 21 the CMS Finance Committee recommended the CMS Board of Directors provide an additional line of credit to the CMS Foundation for the purpose of continuing with development efforts for CROP. The initial line of credit extended to CROP in January 1997 has been used to prepare for the drive that is forthcoming. Campaign leadership is in place, prospective donors have been researched and evaluated, proposals are written and several have been submitted, and outside organizations have begun to offer their assistance with the project. In reviewing the progress made on the project thus far, and in recalling their commitment to help address the physician shortage challenge in rural Colorado, the CMS Board moved to extend a line of credit to carry the project through June of 1998. A review of the capital campaign will be done at the end of April, 1998.

(Continued on page 3)

Balanced Budget Act strikes again:
Medicare participation enrollment extended

This year the annual Medicare participation enrollment period has been extended by one month. Physicians have until February 2, 1998 to either enroll as new Medicare participating providers or *withdraw* from participation. This extension has been prompted, in part, by HCFA's interpretation of the *private contracting provision* of the 1997 Balanced Budget Act. It is their interpretation that a participating physician can only "opt out" of the program (and therefore be eligible to contract privately with a beneficiary) if the physician terminates the Medicare participation agreement during the annual enrollment period.

This is just one more knot in the private contracting noose. It is extremely important for physicians to fully understand the ramifications of "taking advantage" of the private contracting provision as it currently stands. A physician who "opts out" by signing a private contract with a Medicare beneficiary cannot receive **any** money

(Continued on page 3)



Med Fax: Medico-Legal News

by Karen B. Best, Esq., an associate with the law firm of Montgomery Little & McGrew, P.C.

This column contains information concerning topics of general interest in the medical-legal field. For further information or help with specific problems, please contact Montgomery Little & McGrew, P.C.

Negative job references can expose employers to liability

You take a call from an old friend with a different medical group in town where a former employee has just applied for a position. Or, you take a call from the human resources department of a large hospital in another state. The identity of the caller doesnt really matter, but you may be more inclined to be candid with the former than the latter. The prospective employer wants to know about the former employee. Can you be candid?

This particular employee was fired for good cause. He was consistently late for work, called in sick whenever the Rockies were in town. Whenever he was there, his work was unacceptable and he was rude and insulting to his co-workers. Fill in whatever facts would apply to a situation where the employer clearly had valid reasons for terminating the employee.

What can you tell the caller about the former employee? Giving a negative job reference to a prospective employer could expose the medical group to a lawsuit and potential liability. That is not to say that by giving a negative job reference the employer will be held liable or will lose a lawsuit filed by the former employee. I am saying that a negative job reference can form the basis for a lawsuit which could place the employer in the position of having to defend its conduct in court, with respect to the negative job reference.

Unfortunately for employers, who are on the receiving end of these lawsuits, its a no-win situation. Once an employer is sued, it loses (in a sense) by virtue of the fact that it must defend the lawsuit. According to Bests Review Property-Casualty Insurance, (12-2-96), the average cost of employment related lawsuits in 1995 was $53,030. This figure does not account for lost time, lost productivity, or general disruption to the business itself caused by this type of lawsuit.

Colorado statutes provide some protection from liability for employers which act in good faith and give factually accurate information. An employer that, upon request by a prospective employer, or by a current or former employee, provides fair and unbiased information about a current or former employees job performance, is presumed to be acting in good faith and shall be immune from civil liability for the disclosure and the consequences of the disclosure. By statute, the employer may, upon inquiry, give a fair and unbiased opinion of the employees qualifications when solicited by a later or prospective employer. The employee can overcome (rebut) the presumption of good faith by showing by a preponderance of the evidence (more likely than not -- tipping the scales of justice) that the information disclosed was knowingly false, deliberately misleading, disclosed for a malicious purpose, or violative of the employees civil rights. Colorado Revised Statute, section 8-2-114.

Claims potentially arising from negative job references include defamation, outrageous conduct, interference with contractual relations, violation of privacy, negligent misrepresentation, fraudulent inducement, breach of an implied contract of fair dealing, and civil rights violations. It is not difficult to take a few statements and fit them into the elements of a number of these claims. Although the burden is upon the former employee to prove his case, once the lawsuit is filed the employer must nonetheless spend time, money and energy defending conduct which may have been entirely appropriate.

What conduct would place the employer in the best position if it is sued over a negative job reference? Stick to the facts about the employees job performance. Do not engage in speculation, or discuss opinions, judgments, or rumors. Truth is an absolute defense to defamation.

Avoid discussion of non-employment issues such as the employees activities outside of work. At the exit interview, discuss with the employee how the employer will respond to inquiries from prospective employers.

Factual information such as dates of employment, last position held, and salary are the least likely pieces of information to trigger a lawsuit. This is the standard approach adopted by many employers. Opinions are more likely to invite litigation, and are subject to interpretation in court, as to both content and motive.

Do not give false or inaccurate good references. Designate a single person in the company who will handle all inquiries from prospective employers, and instruct other employees to refer all such calls to that person.

Protect the confidentiality of former employees personnel files and documents related to the termination. This sensitive and arguably private information should not be carelessly stored or left open for the eyes of the curious. Educate your employees about this sensitive area of inquiry.

Whether an employer can be held liable for not disclosing negative information about a former employee is unknown. I raise this as a question only, and a consideration in extreme cases where the former employees conduct could pose a threat to the public. One California case was filed against a school for giving a good reference for a known child molester.

Studies have shown that many employment lawsuits are filed by people who believe they were treated shabbily by their employer when they were fired. Disputes about the number of hours of sick and vacation leave remaining, and the way an employee is fired or told to leave the office can, literally, turn into a federal case.

This is an extremely complex area of the law and the information in this article is not legal advice. If you have specific employment questions you should contact an attorney. Montgomery Little & McGrew offers services in the area of employment law.

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(CROP continued from page 1)

The Colorado Medical Society Foundation has been granted its 501(c)(3) status from the Internal Revenue Service and is now capable of receiving funds from virtually any source. The Foundation oversees the administration of CROP and assists with resource development. Members of the Board are: Pat Grant, President (President and CEO of the National Western Stock Show); Pam Laman, Vice President (CMS Alliance member and community volunteer from Pueblo); Terry Sullivan, MD, Treasurer; Sandi Maloney, Secretary; Jack Berry, MD; Bob Hansen (President of Pioneer National Bank in Wray); and Bob Sawyer, MD.

Efforts to raise CROP funds continue both quietly, and thanks to the Aurora-Adams County Medical Society (AACMS), not so quietly. Kudos go out to Dr. Christopher Unrein, President, members and staff of the AACMS for their enthusiasm and energy on behalf of CROP. AACMS sold raffle tickets for a travel package worth $1,500 during the 1997 Annual Meeting to benefit the project. Tickets are still available through the AACMS by calling (303) 756-2718.

(Medicare continued from page 1)

from the Medicare program for a period of two years. This includes payments received not only from the fee-for-service program, but also from any Medicare HMO.

There is a way around this convoluted provision. For Medicare patients who have the financial means to pay privately for all of their professional expenses and have the desire to do so, *they* can "opt out" of Medicare Part B. The Part B program is not mandatory, however, there are penalties for enrolling after you first become eligible. Obviously this is *not* a solution, and is something that only the wealthy could even consider. A better solution will be considered by Congress early in 1998. An amendment has been introduced that would remove the two year isolation from the Medicare program. Physicians and concerned Medicare beneficiaries should let their Congressional leaders know how they feel. The AMA has a sample letter available for this purpose on their web page at http://www.ama-assn.org/advocacy/grassroo.htm. If you do not have access to the internet and are interested, contact Marilyn Rissmiller at CMS on 779-5455 or 1-800-654-5653, ext. 2428 for a copy of the sample letter.

Constituent Skills Workshop

The Colorado Medical Society (CMS) in collaboration with the American Medical Association will hold a Constituent Skills Workshop for physician leaders to prepare and encourage participaticipation in the health care debate during the upcoming legislative session,

The Workshop will take place on Friday, January 23, 1998 in the CMS Board Room. Registration will begin at 8:00 a.m., the Workshop itself begins at 8:30 a.m. and will conclude at 12 noon.

Most of us shy away from getting directly involved in the nuts and bolts of our legislative process. Yet, you are the most effective representative of our cause because you have the specialized knowledge and ability to voice the interests of medicine. We all must be lobbyists - make our ideas and views known to the lawmakers - if we are to win the kind of health care reform that is equitable, fair and practical for all involved. The Constituent Skills Workshop will develop the skills you need to participate in this process.

Call Lorraine Koehn or Suzanne Hamilton in the CMS Government Relations Department at (303) 779-5455 or 1-800-654-5653 for registration details.

FTC settles antitrust suit with Western Slope doctors (See story in this issue.)

In what it called a "corrective solution", The Federal Trade Commission (FTC) settled with the Mesa County Physicians IPA in the FTC suit against the group. The settlement allows the group to continue its contract with Rocky Mountain HMO.

The FTC would not comment on the terms of the agreement, but IPA President, William Kelley, MD, was not hesitant to say that the Mesa County physicians, the majority of whom are members of the IPA, were "very happy about this."

This "preliminry" agreement ends a year and a half struggle between the FTC and the IPA.

Details in the settlement were not revealed; however, ***Colorado Medicine*** will be carrying a complete report on the final decree in the January issue.

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Colorado Medical Society provides the following listings of events as a member service only. Some events are approved for Continuing Medical Education credits. Information is provided by the sponsoring organizations. For more details, use the telephone contact at the end of the listing.

American College of Cardiology
29th Annual Cardiovascular Conference at Snowmass
January 12-16, 1998
Snowmass, Colorado
1-800-253-4636, ext. 695

Medical Education Resources, Inc.
Clinical Diabetes & Endocrinology in 1998
January 18-22, 1998
Snowmass/Aspen, Colorado
18 hours of Category 1 credit
(303) 798-9682 or 1-800-421-3756

National Jewish Medical & Research Center
20th Anniversary National Jewish medical & Research Center Update on Allergy, Asthma & Clinical Immunology
February 4-8, 1998
Keystone, Colorado
Contact: (303) 398-1000 or e-mail at proed@njrc.org

American College of Cardiology
Cardiovascular Conference at Snowbird
February 11-14, 1998
Snowbird, Utah
18.5 Category 1 AMA
1-800-253-4636, ext. 695

Medical Education Resources
Dermatology for the Non-Dermatologist
February 13-15, 1998
Breckenridge, Colorado
11 credit hours in AMA Category 1, 11 credit hours for American Academy of Family Physicians
Contact: Linda Main (303) 798-9682 or 800-421-3756

Colorado Society of Osteopathic Medicine
Ski & CME Midwinter Conference
February 22-27, 1998
Keystone Lodge & Resort, Colorado
38 hours AOA Category 1-A, AAFP prescribed course hours; AAPA credits
Contact: Patricia Ellis (303) 322-1752 or 1-800-527-4578

Medical Education Resources, Inc.
Dermatology for the Non-Dermatologist
February 13-15, 1998
Breckenridge, Colorado
11 hours of Category 1 credit
(303) 798-9682 or 1-800-421-3756

American College of Cardiology
5th Annual Echocardiographic Workshop on 2-D Doppler Echocardiography at Vail
February 23-26, 1998
Vail, Colorado
18 Category 1 AMA
1-800-253-4636, ext. 695

American Lung Association
17th Annual big Sky Pulmonary & Critical Care Medicine Conference
March 25-28, 1998
Big Sky Montana
(406) 442-6556

Send us your calender items.

If your specialty society or hospital is sponsoring a CME event or seminar which would be of interest to physicians in Colorado, have them send the information to: Event Calender, *Colorado Medicine*, P.O. Box 17550, Denver, CO 80217-0550. Please include information detailing program sponsor, date, location and phone number for more information.

Colorado Medicine
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Title/Subject Index

1997 ANNUAL MEETING, June issue, 381-383
1997 CMS elections: candidate statements, 284
1997 CMS Leadership Conference to focus on outcomes, March Medfax
1997 Fall Clinics, August Medfax
1997 INTERIM MEETING, 81, 145
1997-98 HIV/AIDS Clinical Training Program, 392
9Health Fair, 126
9Health Fair, 344
A country physician on the high plains, Garcia, F. A., 262
A decade of service: off to new adventures, 264
A physician's affirmation, Abrams, Frederick Ralph, 52
Academic doctors: who are they and why are they competing? Eckhoff, Donald, 194
Accountability, October Medfax
Address to the CMS House of Delegates Shanks, W. George, 143
After 27 years CFMC is still growing, 409
AHA reports more Colorado children are at risk for heart disease, 87
Alliance day at the Capitol, 168
AMA UPDATE Quinn, Richert E., 50, 281
AMAFPS develops new services to aid physicians and group practices, 124
AMC Cancer Research Center Foundation hires Joel Edelman, 266
Another legacy of Henry Sewall, 209
ARCHIVES OF MEDICINE, Lightburn, John L., 24, 55, 111, 151, 206, 262, 308, 340, 386, 460
Are your insurance claims "lost?" Rissmiller, Marilyn, 108
As integrated as you want to be, 79
Balanced Budget Act strikes again: Medicare participation enrollment extended, December Medfax
Benjamin Cordova, Ed.D named new executive director of CHPP, 347
BME responds to physicians' use of alcohol and other mind altering drugs while on-call, September Medfax
BOARD HIGHLIGHTS, 33, 114, 148, 236, 324, 383
C.R.O.P. generating community interest, February Medfax
C.R.O.P. ploughs ahead, Shevell, Suzi, 240
C.R.O.P. Report, Milstein, Peter B., 27
CACME to intiate statewide domestic violence projects, September Medfax
Call for excessive processing and delayed claims testimonials, January Medfax
Can organized medicine unify? Karlin, Joel M., 18
Cancer clinical trials, Raich, Peter, 442
Careful antibiotic use in Colorado: Background, Lowenstein, Steven, Kenneth Gershman, 456
CCMD proposes adult and neonatal end-of-life guidelines, September Medfax
CFMC to hold outcomes measurement conference, 87
CFMC wins CHAMPUS/Tricare contract, October Medfax
Cloning Joe, Coleman, Thomas H., 198
CME and the evolving system of accreditation, Heth, Lorraine, 241
CMS Alliance places in the top tem for AMA-ERF fund-raising efforts, 126
CMS Board extends CROP line of credit, December Medfax
CMS intorduces new members service, January Medfax
CMS member elected President of Osteopathic Academy, October Medfax
CMS member receives prestigious award, 34
CMS members appointedf to department leadership at Children's Hospital, 87
CMS members win national offices, January Medfax
CMS opposes Medicare Competitive Pricing Demonstration Project, May Medfax
CMS Physicians' Financial Program, 203
CMS representative sought for CFTC Board of Directors, April Medfax
CMS seeks legislative clarification on BME action...and gets it, April Medfax
CMS to hold Drug Formulary Forum, August Medfax
CMS-ERF scholarships awarded to two students, 34
Coding highlights, Rissmiller, Marilyn, 29
Collaborative action or specialty vs. primary care, physician vs. physician, Painter, M. Ray, 45
Colorado BME: disciplinary actions and revised rule for physician assistants, Best, Karen B., September Medfax
Colorado HMO enrollment up, profits down, 463
Colorado Medical Society Alliance, 168, 243, 303, 417, 462
Colorado Medicare carrier awarded six new states, March Medfax
COLORADO PHYSICIAN NETWORK Martz, David C., 13, 64, 115, 155, 195, 235, 279, 335, 370, 407, 443
Colorado program selected to coordinate universal newborn hearing screening, 125

Colorado State Hospital, Lightburn, John L., 151
Colorado Women's Health Campaign created to educate women, 392
Comparative or contributory negligence, Best, Karen B., April Medfax
Computers in medicine? Are you kidding? Poliakoff, Caude S., 67
Conference to address the future of health care, 210
Contract medicine: the good, the bad and the ugly, Painter, M. Ray, 177
Contstituent skills workshop, December Medfax
Cooperation, 16
COPIC COMMENT, Buckley, Jerome M., 21, 54, 107, 150, 200, 251, 302, 332, 391, 425
Council & Committee Appointments, 385
CU School of Medicine gets big donation form CMS and Coloardo AMA-ERF, 267
Definition of screening services, Steffen, Grant, 336
Documentation guidelines for the new single system examination, Steffen, Grant, 388
Domestic violence - did we make a difference? Pierson, William S., 450
Domestic violence and kids: some signs, some help, 326
Domestic violence...Mountain communities respond, 186
Domestic violence: how physicians can help children, Rossman, B.B. Robbie, 364
Dr. Gabow honored as distinguished internist, 210
Dr. John Elsner Lightburn, John L., 420
Dr. Lewin to keynote Caring for Colorado's Underserved, February Medfax
Dr. Rohrer retires, 210
Dr. VanderArk awarded business person of the year, 126
DRCOG resource directory, 126
El Paso County medical ethics essay contest, 266
EXECUTIVE DIRECTOR'S UPDATE, Maloney, Sandra L., 9, 47, 99, 139, 179, 323, 361, 405, 439
Family physicians to celebrate 50th Anniversary, 463
First Colorado Electronic Data Interchange (EDI) Conference for physicians and office managers, July Medfax
Florence Sabin, MD, Lightburn, John L., 386
Follow-up: lost/delayed insurance claims, Register, Edie and Marilyn Rissmiller, 300
Forum on the medically indigen planned for March 7, 1997, January Medfax
Free consulting referrals for physician practices, 311
Free information hotline for medical practice and laboratory services, 210
FTC settles antitrus suit wiht doctors on Western Slope, December Medfax
FTC settles lawsuit with Mesa County Doctors, 463
Gag clauses in physician contracts, Best, Karen B., May Medfax
Gentleman Jim, Lightburn, John L., 24
Grenada accreditation standards comparable to US, 125
HCFA Medicare Managed Care Competitive Pricing Project, 124
HEALTH CARE FINANCING, 70, 345, 430, 454
Help is on the way for solving problems between doctors and third party payers, December Medfax
Henry Sewall, Ph.D., M.D., Lightburn, John L., 206
High touch meets high tech at 1997 Informatics Fair, 347
Highlights of the year end coding/payment changes, Rissmiller, Marilyn, 454
HMO: To be or not to be? VanderArk, Gary D., 401
Homeopathy: what you need to know, Kay, Dennis, 296
How are the children? Shanks, Stella, 243
Ilana Kutinsky, MD, honored for community service, 311
Immunity from liability for professional review activities: Can you count on it? Kuhn, Kevin J., March Medfax
Immunization information alert! January Medfax
Independent medical examinations: Now you see a duty to the patient; now you don't, Best, Karen B., January Medfax
Indicators of abuse, neglect, and exploitation of the elderly, 299
Information technology revolution, CMS and you, Painter, M. Ray, 5
Informed consent: How much do you have to tell the patient? Best, Karen B., October Medfax
Interim legislative committee deliberates over mandatory no-fault auto insurance, October Medfax
John L. Sherman, MD, installed as component society president, 392
La Grippe with a vengance, Lightburn, John L., 340
Leaving the bedside? Yes or no? Truitt, Leigh, 118
Legislative interim committees address no-fault insurance and intractable pain, August Medfax
Let seniors beware, Biehler, Tammy and Vincent Clarkson, 298
LETTERS TO THE EDITOR, 201, 369
Level II physician accreditation and re-accredititation seminars, 125
Level II physician accreditation seminars, 267
Liability aspects of drug interaction software: Part 1 Victoroff, Michael S., 120
Liability aspects of drug interaction software: Part 2, Victoroff, Michael S., 165
LOBBY Allen, Richard, Christopher Unrein, 11, 49, 103, 140, 183,440
*Long range planning: political pain management,*Reed, Barbara R., 242
Major shock wave rolls through physician membership listings or Northern and Central Colorado, 370
Measurable outcomes of primary care curriculum are numerous, Krugman, Richard D., 188
Medical acupuncture: a model of integrated healthcare from alternative to mainstream medicine, Frank, Bryan L., 252
Medical delegation to China, 210
Medical indigence: an action plan for Colorado, 161
Medical licenses expire May 31, March Medfax
Medical malpractice court case awards double between 1985-95, September Medfax
MEDICAL NEWS, 34, 87, 124, 210, 266, 311, 347, 392, 426, 463
Medical savings accounts: Your cure for rising health care costs? Seward, Chet P., 122
Medical society recieves grant to produce tozic environment exposure case studies, 34
Medical, legal and moral concerns surrounding dying patients to be addressed, March Medfax
Medicare E&M Documentation Guidelines updated, 347
Medicare fraud and abuse - the focused medical review, Steffen, Grant, 156
Medicare fraud and abuse: clarifications in the carrier's role, Rissmiller, Marilyn, 256

Medicare fraud and abuse: HCFA definitions, Steffen, Grant, 204
Medicare/Medicaid: fifty ways to commit fraud and abuse, Best, Karen B., August Medfax
Meeting the challenges of the 90s CMS Physicians' Financial Program, 63
MEMBER SERVICES, 28, 63, 203, 333
MEMBERSHIP, 86, 288, 444
MGMA addresses benefits and dangers of new communication technology, 124
Mobilizing for the "Great War", Lightburn, John L., 308
Mountain community domestic violence seminar a success, 267
Moving toward consumer driven health care, Karlin, Joel M., 418
NDMA calls for physician help in flood relief, May Medfax
Negative job references can expose employers to liability, Best, Karen, December Medfax
New airwave technology greets 21st century, 71
New El Paso County Health Department Director, 266
NEW MEMBERS, 258, 445
New officers and board members of the CMS, October Medfax
New TB control regulations, Hoffman, Richard and Randall Reves, 334
Obtaining a birth certificate now is easier in Colorado, 392
Officers assume Orthopaedic Society posts, 311
Outcomes studies: Validity and interpretation, Shapiro, Howard, 452
Pat Clark wins the AMA/Glaxo Wellcome Award, 266
Physician advocacy, Painter, M. Ray, 277
Physician self-perceived risk behaviors and communication, Gardner, Kathy, 57
Physicians and terminal care, Reilly, Gerald D., 366
Physicians' financial program, Halsch, David P., 306
Plains Medical Center named outstanding rural practice, 266
Pointing the way: CMS program year in review, Seward, Chet P., 330
Poverty and disease: a postcare from the edge, Baker, Deborah, 104
President's inagural address, VanderArk, Gary D., 357
PRESIDENT'S LETTER, Painter, M. Ray, VanderArk, Gary D., 5, 45, 97, 137, 177, 233, 277, 321, 357, 401, 437
Questions about telemedicine not yet answered, Seward, Chet P., 72
Rape within a battering relationship, Barnes, Kelsey S., 406
Recognition, Pierson, Bill, 14
Recommendations for transition of care for patients with special needs and circumstances, 17
Remembrance of Dr. James F. Hoffman, Sr., Wise, James, 328
Report to the board, Truitt, Leigh, 238
Resurgent professionalism, 164
Reversing the perception of the CU-Health Sciences Center, Krugman, Richard D., 408
Revised Interprofessional Code now available, July Medfax
Road map to the future, Painter, M. Ray, 321
RUMINATIONS, Pierson, William S., 38, 90, 130, 170, 214, 270, 314, 350, 394, 466
Saint Joseph Hospital named outstanding non-profit in state, 34
School of medicine on the right course, Krugman, Richard D., 61
Snapshots: 1997 Interim Meeting & Medically Underserved Conference, 147
Some thoughts on the CAC's and the LMRP's, Steffen, Grant, 304
Standing room only: Medical indigence in Colorado, Seward, Chet P., 116
Survey of 1996 BME appelate court decisions, Best, Karen B., February Medfax
Taking a stand: caring for Colorado's underserved, VanderArk, Gary D., 159
Talking to your patients about domestic violence: how to encourage them to talk to you, 187
Telemedicine in Colorado: Special Section, 74
Telemedicine rides the Internet, 73
Telemedicine: bigger, better, now! Seward, Chet P., 78
The Denver Medical Library today and tomorrow, Pierson, William S., 113
The Denver Medical Library, Lightburn, John L., 111
The patient is #1, Painter, M. Ray, 97
The revised Interprofessional Code answeres frequently asked questions, July Medfax
The voice of CMS, 458
Town versus gown: competition revisited, Sbarbaro, John A., 196
Traditional vs. virtual medicine: a fight to the finish? Seward, Chet P., 244
Trends in medicine, 210
Two "firsts" in the land of shadows, Lightburn, John L., 55
What about AIDS? Cook, Patty, 380
Where is managed care taking the medical profession? Truitt, Leigh, 12
WIM leadership conference to "recapture the art of healing", 125
Zimm was a great man, Pierson, William S., 153

Author Index

Abrams, Frederick Ralph, *A physician's affirmation,* 52
Allen, Richard, Christopher Unrein, *LOBBY,* 11, 49, 103, 140, 183,440
Baker, Deborah, *Poverty and disease: a postcare from the edge,* 104
Barnes, Kelsey S., *Rape within a battering relationship,* 406
Best, Karen B., *Colorado BME: disciplinary actions and revised rule for physician assistants,* September Medfax
Best, Karen B., *Comparative or contributory negligence,* April Medfax
Best, Karen B., *Gag clauses in physician contracts,* May Medfax
Best, Karen B., *Independent medical examinations: Now you see a duty to the patient; now you don't,* January Medfax
Best, Karen B., *Informed consent: How much do you have to tell the patient?* October Medfax
Best, Karen B., *Medicare/Medicaid: fifty ways to commit fraud and abuse,* August Medfax
Best, Karen B., *Survey of 1996 BME appelate court decisions,* February Medfax
Best, Karen, *Negative job references can expose employers to liability,* December Medfax
Biehler, Tammy and Vincent Clarkson, *Let seniors beware,* 298

Buckley, Jerome M., *COPIC COMMENT,* 21, 54, 107, 150, 200, 251, 302, 332, 391, 425
Coleman, Thomas H., *Cloning Joe,* 198
Cook, Patty, *What about AIDS?* 380
Eckhoff, Donald, *Academic doctors: who are they and why are they competing?* 194
Frank, Bryan L., *Medical acupuncture: a model of integrated healthcare from alternative to mainstream medicine,* 252
Garcia, F. A., *A country physician on the high plains,* 262
Gardner, Kathy, *Physician self-perceived risk behaviors and communication,* 57
Halsch, David P., *Physicians' financial program,* 306
Heth, Lorraine, *CME and the evolving system of accreditation,* 241
Hoffman, Richard and Randall Reves, *New TB control regulations,* 334
Karlin, Joel M., *Can organized medicine unify?* 18
Karlin, Joel M., *Moving toward consumer driven health care,* 418
Kay, Dennis, *Homeopathy: what you need to know,* 296
Krugman, Richard D., *Measurable outcomes of primary care curriculum are numerous,* 188
Krugman, Richard D., *Reversing the perception of the CU-Health Sciences Center,* 408
Krugman, Richard D., *School of medicine on the right course,* 61
Kuhn, Kevin J., *Immunity from liability for professional review activities: Can you count on it?* March Medfax
Lightburn, John L., *ARCHIVES OF MEDICINE,* 24, 55, 111, 151, 206, 262, 308, 340, 386, 460
Lightburn, John L., *Colorado State Hospital,* 151
Lightburn, John L., *Dr. John Elsner,* 420
Lightburn, John L., *Gentleman Jim,* 24
Lightburn, John L., *Henry Sewall, Ph.D., M.D.,* 206
Lightburn, John L., *La Grippe with a vengance,* 340
Lightburn, John L., *Mobilizing for the "Great War",* 308
Lightburn, John L., *The Denver Medical Library,* 111
Lightburn, John L., *Two "firsts" in the land of shadows,* 55
Lightburn, John L., *Florence Sabin, MD.,* 386
Lowenstein, Steven, Kenneth Gershman, *Careful antibiotic use in Colorado: Background,* 456
Maloney, Sandra L., *EXECUTIVE DIRECTOR'S UPDATE,* 9, 47, 99, 139, 179, 323, 361, 405, 439
Martz, David C., *COLORADO PHYSICIAN NETWORK,* 13, 64, 115, 155, 195, 235, 279, 335, 370, 407, 443
Milstein, Peter B., *C.R.O.P. Report,* 27
Painter, M. Ray, *Collaborative action or specialty vs. primary care, physician vs. physician,* 45
Painter, M. Ray, *Contract medicine: the good, the bad and the ugly,* 177
Painter, M. Ray, *Physician advocacy,* 277
Painter, M. Ray, *Road map to the future,* 321
Painter, M. Ray, *The patient is #1,* 97
Painter, M. Ray, *Information technology revolution, CMS and you,* 5
Painter, M. Ray, VanderArk, Gary D., *PRESIDENT'S LETTER,* 5, 45, 97, 137, 177, 233, 277, 321, 357, 401, 437
Pierson, Bill, *Recognition,* 14
Pierson, William S., *Domestic violence - did we make a difference?* 450
Pierson, William S., *RUMINATIONS,* 38, 90, 130, 170, 214, 270, 314, 350, 394, 466
Pierson, William S., *The Denver Medical Library today and tomorrow,* 113
Pierson, William S., *Zimm was a great man,* 153
Poliakoff, Caude S., *Computers in medicine? Are you kidding?* 67
Quinn, Richert E., *AMA UPDATE* 50, 281
Raich, Peter, *Cancer clinical trials,* 442
Reed, Barbara R., *Long range planning: political pain management,* 242
Register, Edie and Marilyn Rissmiller, *Follow-up: lost/ delayed insurance claims,* 300
Reilly, Gerald D., *Physicians and terminal care,* 366
Rissmiller, Marilyn, *Coding highlights,* 29
Rissmiller, Marilyn, *Are your insurance claims "lost?"* 108
Rissmiller, Marilyn, *Highlights of the year end coding/ payment changes,* 454
Rissmiller, Marilyn, *Medicare fraud and abuse: clarifications in the carrier's role,* 256
Rossman, B.B. Robbie, *Domestic violence: how physicians can help children,* 364
Sbarbaro, John A., *Town versus gown: competition revisited,* 196
Seward, Chet P., *Medical savings accounts: Your cure for rising health care costs?* 122
Seward, Chet P., *Pointing the way: CMS program year in review,* 330
Seward, Chet P., *Questions about telemedicine not yet answered,* 72
Seward, Chet P., *Standing room only: Medical indigence in Colorado,* 116
Seward, Chet P., *Telemedicine: bigger, better, now!* 78
Seward, Chet P., *Traditional vs. virtual medicine: a fight to the finish?* 244
Shanks, Stella, *How are the children?* 243
Shanks, W. George, *Address to the CMS House of Delegates,* 143
Shapiro, Howard, *Outcomes studies: Validity and interpretation,* 452
Shevell, Suzi, *C.R.O.P. ploughs ahead,* 240
Steffen, Grant, *Definition of screening services,* 336
Steffen, Grant, *Documentation guidelines for the new single system examination,* 388
Steffen, Grant, *Medicare fraud and abuse - the focused medical review,* 156
Steffen, Grant, *Medicare fraud and abuse: HCFA definitions,* 204
Steffen, Grant, *Some thoughts on the CAC's and the LMRP's,* 304
Truitt, Leigh, *Leaving the bedside? Yes or no?* 118
Truitt, Leigh, *Report to the board,* 238
Truitt, Leigh, *Where is managed care taking the medical profession?* 12
VanderArk, Gary D., *HMO: To be or not to be?* 401
VanderArk, Gary D., *President's inagural address,* 357
VanderArk, Gary D., *Taking a stand: caring for Colorado's underserved,* 159
Victoroff, Michael S., *Liability aspects of drug interaction software: Part 1,* 120
Victoroff, Michael S., *Liability aspects of drug interaction software: Part 2,* 165
Wise, James, *Remembrance of Dr. James F. Hoffman, Sr.,* 328

Executive Director's Update



Sandra L. Maloney
Executive Director

Mark Twain said it:

"We should be careful to get out of an experience only the wisdom that is in it - and stop there; lest we be like the cat that sits down on a hot stove-lid. She will never sit down on a hot stove-lid again, and that is well; but she also will never sit down on a cold one anymore."

We should remember it!

"If yours happens to be one that's at risk. . ."

1997 has certainly been a good year for Colorado Medical Society, although no single event or accomplishment jumps out at me as exceptional or memorable. That's right; I said it, but there were many, many accomplishments. Because there were so many it is difficult to single out one or two as major gains made.

- CMS was able to avoid numerous assaults (most of them 'nuisance' bills) on the Medical Practice Act.
- 1997 was the year that the Colorado Medical Society got crackin' with a Formulary Task Force, and this effort promises to grow into a major accomplishment.
- We have a new collaborative effort through the Joint Data Project, working with managed care organizations to improve the quality of health care.
- 1997 was the year CMS sponsored the First Annual Conference on the Medically Underserved, a hugely successful effort that has launched an entirely new community-wide health care initiative.
- The Year of Accountability (and Beyond) is upon us, as a result of the 1997 installation of Dr. Gary VanderArk as CMS President.
- I am especially proud of the accomplishments this year of our staff, which has shown a continuing commitment to the job to be done. Our staff knows the pleasure and satisfaction of working for the CMS membership.
- This is the year of CROP (Colorado Rural Outreach Program), and much good work has been done to establish this totally-CMS effort to maintain medical excellence in rural Colorado. Our development of the CMS Foundation ***(501[c][3])***, which is the primary body of work behind CROP, has been met with enthusiastic acceptance and participation by those persons asked to serve.
- Every council, committee and task force of CMS has played a vital role in the successes enjoyed this year, and their work will have a distinct bearing on the success of organized medicine for years to come. Each of these volunteer groups is working now to prepare this organization for the 21st century. If it weren't for CMS, Colorado physicians would go into the turn of the century without the confidence or assurity of a support group. Believe me when I say I can see physicians in the 21st century **needing** a support group.

Has your ox been gored lately?

- The practice of medicine is changing! And physicians had better be ahead of the curve, changing to fit the needs and moods of the patient-public. This may require the slaughter of some sacred cows. If yours happens to be one that's at risk, then the best place for you to be is with the (CMS) herd to either change public opinion, or change doctor practices to fit the occasion. The chief responsibility of CMS is working to see that you are well advised in the changing climate of your practice, monitoring public trends and movements in health care, keeping you positioned with the other health care professionals to be of the best service to your patients.
- One thing we haven't changed dramatically this year is the amount of work done by the few for the benefit of the many. What that says is: "We need **your** active participation, too!"
- We've learned a lot this year about the ills that may befall medicine. We want no more from the experience of 1997 than the wisdom that's in it, working to stay abreast of your needs and moods.
- If **you** think we're about to sit on a hot stove lid again.... warn us!

We can't always check the fire in your stove; **you'll have to tell us** if we're not sitting in the right spot.

The Lobby



Christopher Unrein, DO, Chairman, Council on Legislation

"Constituent Skills Workshop . . ."

The 1997/98 Council on Legislation begins regular meetings on December 3rd and we're pleased to welcome several new members: Thomas Allen, MD, Loveland; Alfred Carr, MD, Longmont; Mary Jo Jacobs, MD, Joel Karlin, MD, Clear Creek, Denver; Walter "Ben" Vernon, MD, Englewood, and Claudia Wyrick, MD, Highlands Ranch. These physicians will join the following members who served as Council members during 1996/97: Drs. Ben Galloway, Denver, David Hutchison, Denver, Brian Johnson, Broomfield, Larry Kipe, Craig, Jeremy Lazarus, Englewood, Alethia Morgan, Pueblo, D. B. Thatcher, Colorado Springs, and me. The Council is staffed by Lorraine Koehn, Director of Government Relations and Suzanne Hamilton, Program Manager/Lobbyist. We will miss the talents of Dr. Richard Allen who led the Council for the past three years. Thank you, Dick!

The Council represents the Society in all matters pertaining to federal, state and local legislation and legislative bodies. It promotes the determined policies of the Society with regard to: a) all proposed or pending health-related legislation, and (b) the formulation of rules and regulations of governmental agencies for implementation of existing laws. The Council seeks advice and assistance from other appropriate Councils or Committees in arriving at policy recommendations.

The 1998 Colorado Legislature convenes on January 7th and we are anticipating an extremely active legislative session. Proposals which we expect to surface within the next 120 days include bills which (1) will increase the surcharge on medical license fees to support the Colorado Physicians' Health program; (2) allow chiropractors with some advanced training to prescribe; (3) require "hold harmless" clauses in managed care contracts; (4) allow managed care hospital pharmacists prescription privileges when they enter into a collaborative agreement with physicians; (5) addresses telemedicine and requires out-of-state physicians to hold a Colorado license for serving patients being treated within the state; (6) prohibits physician assisted suicide in the state; (7) establish funding mechanisms of children's health care; (8) establishes a needle exchange program, and (9) provides for a medical student loan payment program for graduates who agree to serve in the Department of Corrections. Our current list which grows almost daily currently contains 10 other measures of interest to the medical community. Those of you who have access to the CMS Home Page may keep abreast of legislative happenings via computer. Click the "Heard on the Hill" button at *http://www.cms.org.*

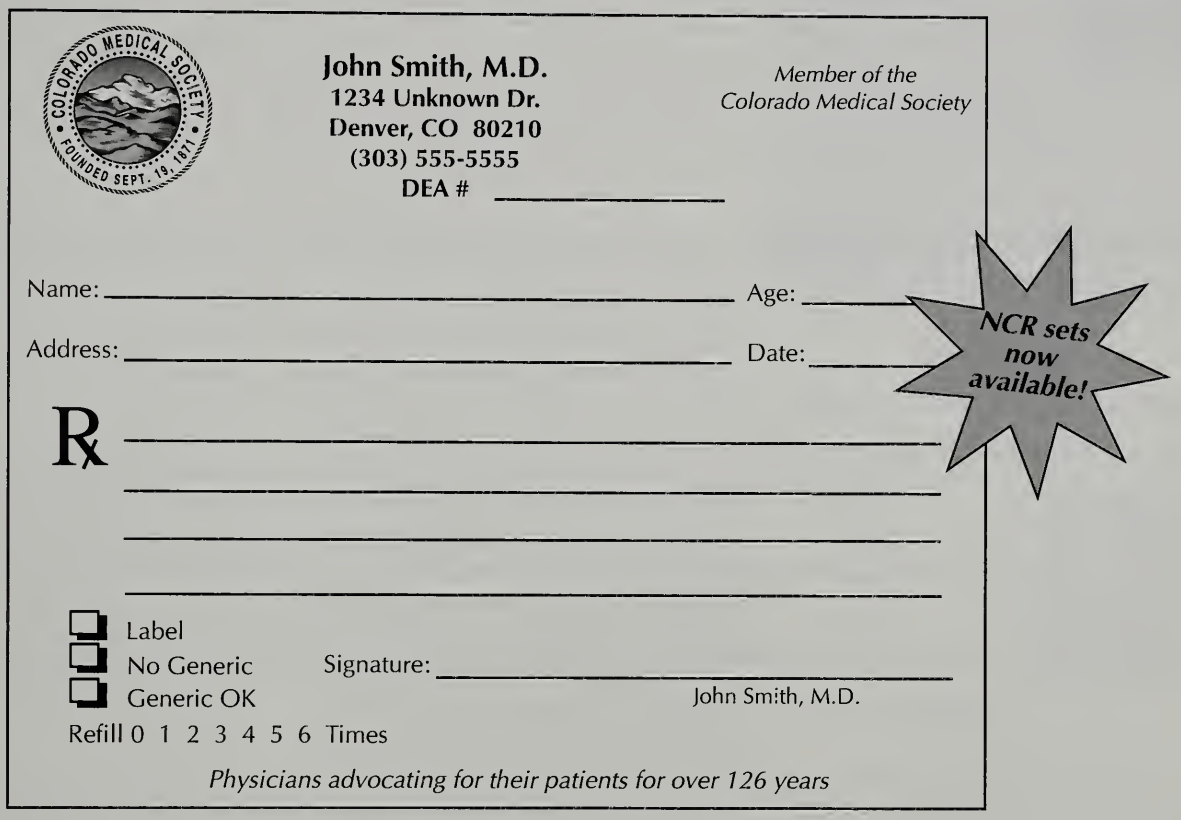
Representative Larry Schwarz, Wetmore, resigned from the legislature to accept a position with the Department of Corrections. He has been replaced by Lola Spradley of Beulah, Colorado. Speaker Berry appointed her to serve on the Business Affairs and Labor and Agriculture Committees.

Staff of the CMS Government Relations Department is in the process of updating our Key Contact (KC) Program. Those of you who have served as a KC in the past will be contacted within the next month to determine if you will continue helping us assure CMS positions on legislative proposals are understood by your local legislators. We're always looking for physicians and spouses ready to help in this arena. You are encouraged to contact either Lorraine Koehn or Suzanne Hamilton at the CMS offices if you are willing to meet with a legislator in your area or if you have questions concerning the program.

CMS, in collaboration with the AMA, will be presenting a "Constituent Skills Workshop" beginning at 8:30 AM on January 23, 1998. The workshop will focus on (1) the political environment for medicine; (2) why grass roots political action is necessary; (3) understanding the legislative process, and (4) how to become a player in the legislative process. We encourage CMS, Component and Specialty Society leaders and Key Contacts to attend this half-day presentation. You may contact CMS Government Department staff for additional information at (303)779-5455, Ext. 410 or 427.

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Orders must be received by February 28, 1998 for this quarter's printing.

Order today and let your patients know that you are a proud member of the Colorado Medical Society advocating excellence in the profession of medicine.

The Cancer Clinical Trials Task Force of Colorado

by Peter C. Raich, MD
for the Cancer Clinical Trials TaskForce

". . . a heightened awareness of the crucial role of clinical trials . . ."

Colorado physicians and patients have access to new cancer treatment approaches, investigational agents and cancer prevention and control strategies by participating in National Cancer Institute (NCI) approved clinical trials through the University of Colorado Cancer Center and the Colorado Cancer Research Program. However, nationwide it is estimated that only three to five percent of adult cancer patients participate in clinical trials. Many factors inhibit greater participation, including the fact that the cost of care for patients on such clinical trials often are not covered by the patients' health plans. A recent survey of medical oncologists throughout the US indicated that 37 percent of respondents reported insurer denial of approval for participation in a clinical trial for at least one of the physician's patients, and 38 percent indicated that they would place at least one additional patient on a clinical trial if the insurer were to cover the cost.[1]

The *Cancer Trials Task Force of Colorado* was formed two years ago in order to find a non-legislative solution to the uncertainty of coverage by third party payers for cancer patients on clinical trials. The *Task Force* evolved from an initial meeting held in December 1994 with Blue Cross/Blue Shield officials and representatives of the Colorado Medical Society and the American Cancer Society. Shortly thereafter a meeting with officials from the then FHP was also encouraging, and regular meetings have been held since, including, in addition to the above, representatives from the major Colorado health plans, as well as from the Rocky Mountain Oncology Society, the University of Colorado Cancer Center and the Colorado Cancer Research Program (CCRP), a consortium of nine front range community hospitals.

During the past two years the *Task Force* has provided information and education about the role of clinical trials in providing effective cancer treatment and answering clearly defined questions to guide future therapies. Specific NCI and FDA approved cancer treatment clinical trials are reviewed by a panel of community and academic cancer specialists. Three levels of information about these trials are provided or made available to the medical directors of the HMOs. The first is a concise "Fact Sheet", which summarizes the major treatment components in the trial, identifies potential benefits versus side effects and toxicities, if any additional costs are engendered, if any agents are provided free of cost, and a brief scientific evaluation. The second is the "Fact Sheet" which is a two to four page summary of the salient portions of the clinical trial protocol. The third is the complete study protocol, which is available on request. This review process concentrates on those studies that are expected to have a sizeable accrual in Colorado, or where challenges have occurred or might be expected.

The establishment of this non-confrontational approach to increase coverage of patient care costs for patients on peer-reviewed Phase III cancer clinical trials was unique in 1995. Since then other efforts have been reported which extend coverage to certain populations on specific clinical trials. In 1996, the Department of Veterans Affairs came to an understanding with the NCI to cover the costs of their patient on NCI-approved clinical trials. Also, in 1996, the national Blue Cross/Blue Shield Plans agreed to provide its clients with access to pediatric cancer clinical trials through the two national childhood cancer cooperative study groups. In September of 1997, three adult cooperative groups sponsored by the NCI reached agreements with several health insurance plans in Wisconsin and Minnesota to cover care costs of patients on clinical trials through these cooperative groups.

The response to the Colorado program has been an enthusiastic endorsement by the health plan organizations and the providers, including financial support to the *Task Force* coordinating office

located at the offices of the Colorado Cancer Research Program. The implementation of this program has been associated by fewer denials for clinical trials coverage, a heightened awareness of the crucial role of clinical trials in defining new treatment strategies, and an appreciation of the need to invest in present clinical trials in order to be able to set accepted standards for future therapies.[2] We are in the process of assessing the program's impact with a participant questionnaire and with tracking of denials, impact of follow-up information, and ultimate outcome.

The author encourages any physician interested in the activities of the *Task Force* or wishing to relate difficulties with patient coverage for clinical trials to contact:

The Cancer Clinical Trials Task Force of Colorado
c/o Ms. Susan Reddy
Colorado Cancer Research Program (CCRP)
3955 E. Exposition Ave. Suite 104
Denver, CO 80209
FAX: (303) 777.2642
Tel: (303) 777-2663
1-800-785-6789
e-mail: ccrphp@aol.com

References:

1. Mortenson LE et al. The impact of managed care on oncology practice. Oncology issues Sept/Oct:22-27, 1997

2. Raich PC et al. Can HMOs be educated regarding cancer clinical trials? J Cancer Education Supplement to 12(3):96, 1997

Colorado Physician Network, Inc.



by David M. Martz, MD
President CPN

Plains Medical Center Best in USA!

Last month we paid tribute to our collaborative associate, RMHMO, on their rating as number one Colorado HMO in consumer satisfaction. This month we wish to highlight the designation of our CPN physicians at the Plains Medical Center in Limon as The Outstanding Rural Practice in America!

The first Coloradans to win such distinction from the National Rural Health Association, they were tops among nominees from all over the United States. Committed to comprehensive, high quality, state-of-the-art medical care in the rural setting, Drs. Mark Olson, John Fox, Richard Book (CPN Board member), Tarek Arja, Jana Jacobs, and Lisa Harner staff four clinic sites on the Eastern plains. Assisted by four mid-level providers utilizing facilities in Limon, Hugo, Flagler and Strasberg, they serve a population base of 25,000 and anticipate 35,000 patient visits in 1997. In addition to acute care, OB, and limited surgical procedures, they provide on-site expertise in virtually all specialties by integrating metropolitan consultants on a regular basis. Numerous other rural communities have developed similar services specifically patterned on the Plains Medical Center template.

Business manager Debbie Olson who has worked there for 25 years, credits the vision and stability of the "Limon Doctors Committee" (a non-physician board of community leaders) for the creation and growth of this unique organization. Founded in 1963 by Dr. John Straub who practiced in eastern Colorado until he retired in 1980, Plains Medical Center was purchased at that time by the local board and organized as a non-profit community owned medical facility. For several years it was staffed by a series of National Health Corps physicians, including Dr. Michael Victoroff and Tom Jeffers. The existing contingent began with the arrival of Dr. Mark Olson 12 years ago, and "the rest is history".

As CPN idealists, we are proud to affirm that our members are modeling health care of the highest standards all across the state. And we salute our colleagues--and the community that supports them--in the Plains Medical Center. "Colorado, you never had it so well!"



Continuing the trend

CMS continues to experience membership growth, however it has not been as dramatic as that seen in 1995-1996. Most of the 1997 membership numbers are now in, and the trend seems to have steadied above the 5,200 level. Overall, CMS membership maintains a growing majority of the licensed, practicing physicians living in the state.

The graph below illustrates dramatic growth in membership from 1995-1997. It also shows the cyclical nature of dues billing, drops and payments. Three trends stand out: the decline between the months of February to April, the gradual march back up to previous numbers, and the resurgence of growth from August through September. The first trend can be simply explained by the fact that the first dues installment deadline is January 15, and the corresponding drop generally occurs during February. Note the declines in all three years between January and April. 1997 witnessed the largest drop with over 200 members. After the drop the second trend initiates a slow move toward reclaiming the numbers from the beginning of the year. August marks the beginning of the third trend. Final counts, which are used to determine each component society's proportional representation in the CMS House of Delegates by elected Delegates and Alternate Delegates, are taken at the end of September. Redoubled efforts to finalize any pending member elections generally start in August.

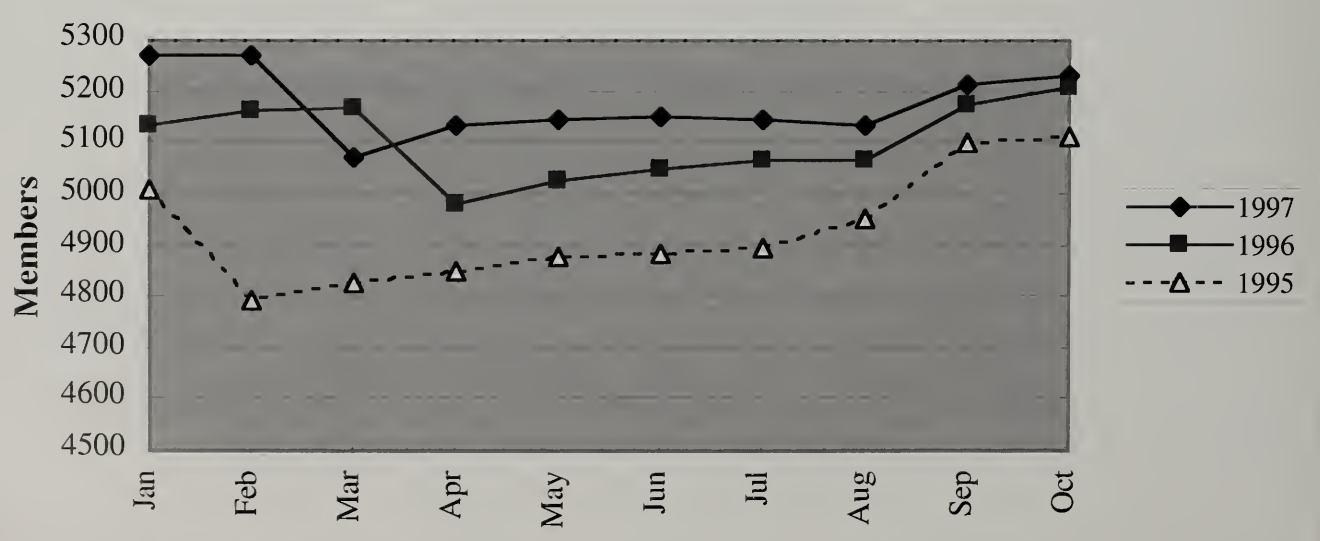
As of October membership in CMS topped out at 5,234, just seven physicians below the 1996 figures. Average numbers for 1997 are clearly higher than the two previous yeas with active members composing 79 percent of total membership, followed by dues exempt members with 15 percent and resident and student members with six percent.

CMS hopes to raise the level of resident and student membership during the coming year. Recruitment efforts hinge on free CMS membership for students and residents. It is believed that by getting the younger physicians involved early in organized medicine, they will have a greater tendency to stay involved throughout their career.

Cyclical downturns in membership can be expected. CMS continues to focus its energy on improving the reciprocal upswing in growth.

Figure 1

CMS Membership



New Members

Please welcome these newly elected members of the Colorado Medical Society.

Arapahoe Medical Society
Lisa A Becker, MD
Teri J Cottingham, MD
Barrett E Cowan, MD
Barbara A Esses, MD
Edward A Harrington, MD
Sonia A Jotte, MD
Burt B Katubig, MD
Marissa S McDonnell, MD
Cherrie M McKitterick, MD
Mary L Melia, MD
William F Pfeifer III, MD
John A Reister, MD
Cameron S Schaeffer, MD
Raewyn D Shell, DO
Wilfred B Szerenyi, MD
Kosta M Zinis, MD

Aurora-Adams County Medical Society
Christopher P Caputo, DO
Richard E Carlson, MD
Dane R Floberg, MD
Wendy L Waters, MD

Boulder County Medical Society
Korina R Bersentes, MD
Paula A Crenshaw, MD
James B Downey, MD
Jon M Erickson, MD
Shimoda Mako, MD
Richard A Miller, MD
Roger D Nichols, MD
Michael K Rakotz, MD
Heather D Rowe, MD
Peter M Schmid, DO

Clear Creek Valley Medical Society
Todd W Beatty, MD
Kevin R Clemmer, DO
David R Ehrenberger, MD
Mitchell A Fremling, MD
W Paul Gessner, MD
Diane M Hartman, MD
Stanley P Hill, MD
David L Hurt, MD
Arlyn J LaBair, MD
William E Lee, MD
Richard G Levine, MD
Jeffrey H Miller, DO
Kristin L Moreau, MD
Thomas F Rehring, MD
Tracy H Saffer, MD
Ranee M Shenoi, MD
Thomas M Wilcox, DO

CMS Direct
Gina C Bamberger, DO
Robert Billow, DO
Timothy S Church, MD
Catherine C Cothren, MD
Lisa D Davidson, DO
Marc A Doucette, MD
Daniel B Eisen, MD
Bruce W Evans, MD
Julius W Gee, DO
Constantine A Georgiadis, DO
Laura F Giordano, MD
Matthew A Goldman, MD
Kenneth M Handlon, MD
Alden K Haun, MD
Jennifer K Hepp, DO
Randall G Hoffman, DO
Jason M Jacobs, MD
Ned Jaleel, DO
Gregory M Margolin, DO
Roger J Matthews, DO
Michael S McCracken, MD
Daniel P O'Brien, DO
Steven G Roberts, DO
Vernon M Rubick, DO
Donald W Runyan, DO
Scott C Russell, DO
Eric D Smith, MD
Maxwell A Snead III, MD
Stephen T Spates, MD
Sam A Wallace, DO

(Continued next page)

New members *(continued)*

Denver Medical Society
Steven A Abrams, MD
Gregory C Allen, MD
Robert P Allen, MD
John F Bealer, MD
Geoffrey A Block, MD
James C Chappell, MD
Khalid Chowdhury, MD
Marvin F Ewy, MD
Amy C Fairfax, MD
Terry I Finlayson, MD
James M Greene, MD
Ashish K Gupta, MD
David S Hollander, MD
Valerie A Imperial, MD
Daniel H Jacobson, MD
Sanjay Jatana, MD
Scott A Keeler, MD
Lisa M Latts, MD
Steven R Lowenstein, MD, MPH
Mark Malyak, MD
Joseph H Marceny, MD
Paul T Mikulecky, MD
Kevin B Miller, MD
Leon E Noel, MD
Leslie A O'Meara, MD
Steven H Peck, MD
Mark H Prather, MD
Julie A Pysklo, MD
Carolyn Quan, MD
Lisa M Schilling, MD
Susan E Teitsma, MD
Vernon W Walters, MD

El Paso County Medical Society
Mark L Anders, MD
Jeffrey J Baker, MD
Thomas J Bartlett, MD
Lauren E Bianchi, MD
Patricia A Fodor, MD
William R Frost Jr, MD
Timothy S Hart, MD
Howard L Kremer, MD
Michael R Kuskie, MD
Mary R Laird, MD
James C Lukban, DO
John T Mahan, MD
Lawrence M Martinek, MD
Brian K Metz, MD
Randy L Nitcher, DO
Julie E O'Brien, MD
Bhaktasharan C Patel, MD
Diane H Pelto, MD
Michelle A Ridnour, MD
Christopher T Ruskey, MD
Ronald C Russo, MD
Thomas R Sachtleben, MD
Alexander Senkoff, MD
Richard J Taylor, MD
Farrel K VanWagenen, MD
Patricia L Weber, MD
Gary N Weiss, MD
Bertram T Willman, MD

Huerfano County Medical Society
Lori S Moll, MD
Michael A Moll, MD

Intermountain Medical Society
Joseph M Ferrara, MD

La Plata County Medical Society
James A Birgenheier Jr, MD

Larimer County Medical Society
John R Bodenhamer, MD
Thomas C Coburn, MD
Kristen G Dillon, MD
Nathan L Guerette, MD
John J Hagan, MD
Gina E Heath, MD
Michael J Houghton, MD
John M James, MD
Susan K Klingner, MD
Diane P Nowak, MD
Joel W Parliment, MD
Christina E Pierucki, MD
Fredrick W Van Hook, MD
Janell R Wozniak, MD

Las Animas County Medical Society
Daniel A Driscoll, MD

Medical Student Component
Richard W Hendershot
Regan R Lawson
Randall J Nett
ennifer L Rabaglia
Michael J Sorna
Whitney M Swanger
Jason C Wagner
Michael J White
Sheri A Widner

Mesa County Medical Society
L Edward Ellinwood, MD
Paul C Padyk, MD
Rebecca S Tolby, MD
William J Waterhouse, MD

Montezuma County Medical Society
Edwin M Wyman, MD

Morgan County Medical Society
Ali I Musani, MD

Mt. Evans Medical Society
Steven R Russell, MD

Mt. Sopris County Medical Society
Ronald M Razzore, MD
Katha Rossein, MD
John J Ryndfleisz, DO

Northwestern Colorado Medical Society
Mary L Bowman, MD

Pueblo County Medical Society
Sally Berryman, MD
Scott W Harberts, MD
Maureen L Key, MD
Mitchell L Lewis, MD
Stephen T Rust, MD
Rina K Shinn, MD
Stanley C Sicher, MD
Ernest W Steinle, MD
Dean Q Volk, MD

San Luis Valley Medical Society
Gerald J Hobson, MD
Katherine T Ottaway, MD
Michael D Van Anrooy, MD
Norman G White, MD

Weld County Medical Society
Mark F Berntsen, MD
Robert L Chandler, MD
Dana L Christiansen, MD
Peter R Coelho, MD
Robert L Dupper, MD
Jacqueline M Eriksen, MD
Thomas A Kenigsberg, MD
Meshelle M Kolanz, MD
Wendy S Lankford, MD
Robert J McLaughlin, MD
Kevin K Nasseri, MD
Gina L Parlato, MD
Sara S Plackner, MD
Catherine H Romero, MD

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Looking back on 1997...



Editor's note:

CMS leadership was asked to review and respond to the Society's accomplishments and/or shortcomings of 1997. They were then asked to envision how the Society will fare in 1998.

The following are the personal views of those physicians who participated.

Medically Underserved Conference

During the Interim Meeting last March we organized a meeting which we called "Caring for Colorado's Medically Underserved". We hoped to attract 100 people, but it turned out to be much more popular than we anticipated. More than 234 people showed up. From that conference, a dedicated group of workers has emerged. The Coalition on the Medically Underserved is presently developing a comprehensive action plan for Colorado.

On March 13, 1998, we will have our second "Caring for Colorado's Medically Underserved Conference". It's going to be bigger and better than the first. The Conference will include national speakers, a report on the action plan for Colorado, a poster session highlighting all existing programs within the state and an inspirational awards banquet. All of this will be accomplished with no cost to CMS members.

Gary D. VanderArk, MD
President, Colorado Medical Society

Resident Physician Section

The Resident Physician Section was once again idle. There would see to be a great deal of inertia to overcome in order to mobilize this group. Leadership within the section is a problem – or was a problem this past year because of lack of participation and time constraints. Recently, The CMS House of Delegates approved the forgiveness of dues for residents. While this may have been motivated by selfish political interests of individuals within the CMS, it encourages further complacency. I recommend that Colorado University staff pay minimal dues and that a leadership development program for residents and medical students be established.

Steve Batuello, MD
CMS Board of Directors

CMS House of Delegates

During 1997 Ted Lewis, MD, past speaker of the House, and I tried to make the House more "user friendly" by revising the *Proceedings of the House of Delegates* and holding an orientation session for new Delegates and Alternate Delegates at the Annual Meeting. We surveyed the other 49 state Speakers to ask about "pearls and "pitfall" in running the House. The 27 responses were full of suggestions.

A resolution which would have diminished the House's authority to determine policy was soundly defeated at the Annual Meeting. However, we're aware that the House must remain truly representative of CMS membership. Accordingly, we've organized a Task Force to study various issues, especially those of communication and representation.

Sherri Laubach, MD, and I are probably the only two women chairing a state society House of Delegates. We look forward to our term with enthusiasm. One of our goals is to bring "continuous quality improvement" to the House. We welcome your ideas.

Louise McDonald, MD
Speaker, CMS House of Delegates

CMS Board of Directors

The CMS Board of Directors has functioned as a group of physician peers striving to represent physicians across the state. The formation of the Coalition for the Medically Underserved is one demonstration of a redirected focus on patient advocacy. Protecting the interests of the underserved will sustain the entire health care industry by promoting health communities. Patients must be priority one, and legislative reform promoted by CMS demonstrates the Society's true colors. It is though these actions that it should be evident to the legislature that CMS is becoming even more of an advocate for patients.

Looking to 1998, the CMS needs to remain focused on these important issues, always keeping the patients as our number one priority. In addition, we also must examine the needs of the physicians in Colorado.

Elaine N. Scholes, MD
CMS Board of Directors

Drug Formulary Study Group

Since March, CMS members have been meeting on a monthly basis with pharmacy directors of insurance companies that are members of the Colorado Health Maintenance Organization Association (CHMOA). To-date agreement has been reached on the format of a simplified, standardized formulary system designed to contain the preferred drugs of each managed care company in a loose-leaf notebook which may be easily updated and kept in each examining room. The first of these simplified formularies have been completed and will soon be tested by physicians in select areas. If acceptable, they would then be available to all CMS members. Progress is also being made in development of a standard for pre-authorization of non-formualry drugs.

Howard E. Netz, MD
Co-chair Drug Formulary Study Group

Arapahoe Medical Society

The Arapahoe Medical Society (AMS) had another successful year in 1997. Chief among its accomplishments were: the expansion of the *Doctor's Care* concept of providing care for the medically indigent in Aurora; the Professional Review Committee functioning as a great forum for quality issues; and the continued success of the physician referral service.

AMS also played an active role in physician advocacy. Educational seminars on the State Board of Medical Examiners, Colorado Physician Health Program and Medicare Fraud were helpful.

Looking forward to next year, we need to better understand the needs and expectations of the entire health care community. Questionnaires are being developed for both the community and physicians.

Roy E.Carlson, MD
CMS Board of Directors

Task Force on Youth

I believe that the work of the Task Force on Youth has been worthwhile. Members of the Task Force have taken direction from a CMS resolution and designed a very good method of raising awareness among physicians and non-physician providers about youth fatalities and injuries resulting from access to a firearm in the home. I believe the Task Force should continue its efforts but we need more direction from CMS leadership. Task Force members have had some difficulty determining what efforts or type of project would truly rouse the interest and excitement of CMS members. Perhaps the most frustrating thing about my experience as Chair of the Task Force is poor meeting attendance. I believe a more thoroughly defined direction for the Task Force would make this concern inconsequential.

Mark Johnson, MD, MPH
Chair, Task Force on Youth

Clear Creek Valley Medical Society

Clear Creek Valley Medical Society (CCVMS) supported CMS by participating in the Key Contact program used for legislative alerts, drafting a resolution that advocates for physicians by reviewing BME and CPHP actions, and by attending meetings of the HOD and various committees and councils. These efforts will continue in 1998.

A decline in membership, compounded by the needs to increase young physician involvement and demonstrate real value for membership dues remain serious concerns.

Sherri Laubach, MD
Vice Speaker, CMS House of Delegates

Weld County Medical Society

In 1997, Weld County Medical Society provided an effective member forum. Although few members have expressed specific concerns to me, I think they have been well served by the Society's response to medical issues.

Physician fellowhip through our membership meetings has been beneficial to all. CMS, by our invitation, has participated in the educational portion of these meetings, to the great benefit of the Weld County Medical Society members.

1997 saw occasion to reconstitute and apply a grievance committee function for one of our members. This is an important avenue that should be available to patients and families regarding a physician in our Society.

Our Executive Committee has begun a research/education/information committee concerning alternative medicine. It will be interesting to see what function this committee assumes.

1998 looks like an active year as well. Colorado Medical Society's support of Weld County Medical Society is much appreciated. Hopefully we can contribute in return.

Joseph A. Tyburczy, M.D.
CMS Board of Directors

... looking forward to 1998



Editor's note:

CMS is already into its 1997-1998 Program Year by two months. 1998 calendar year promises to be one of considerable accomplishment by organized medicine in Colorado as the adjustments and contributions to the age of managed care are made.

CMS Committees

In 1997 I was a member of the newly-formed Long Range Planning Committee but I was released from further work on that committee. I feel that my release was quite inappropriate and certainly not in the best interest of the Society. I had resigned from the Workers' Compensation Committee (after serving ten years) so I could devote more time to what I thought was going to be Long Range Planning Committee's considerable task.

I was also assigned to the Patient Advisory Committee. The committee functioned for about a year and a half working on a publication to advise consumers on health care choices. The proposals were, however, stymied by costs of publication. It is my belief that the Patient Advisory Committee accomplished little in its existence.

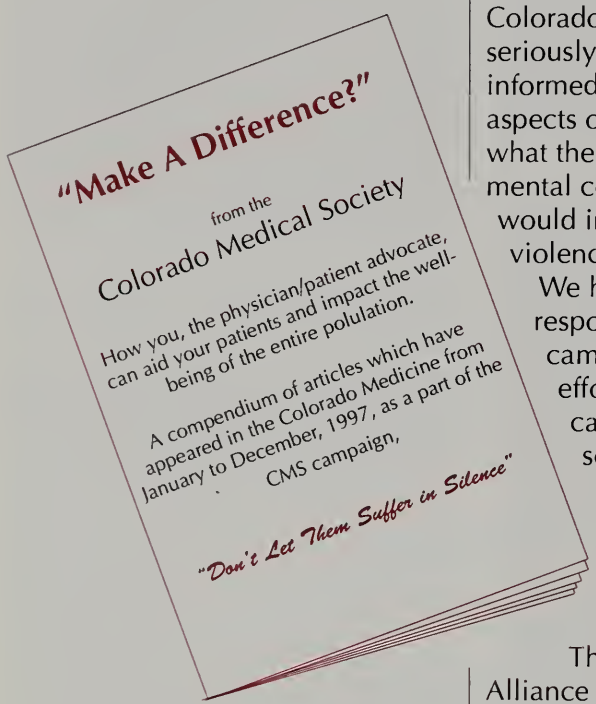
I believe the Workers' Compensation Committee is an excellent committee, and it is essential that the committee's work be carried on. My 10 years on the committee were well spent, but I think it is time to move on.

Harold A. Yocum, M.D.
CMS Board of Directors

Domestic Violence:

Did we make a difference?

by Bill Pierson
Managing Editor



Who's to say? If you noticed our efforts at reminding you each month that domestic violence is very much a necessary part of the physician's practice, then we've accomplished a great deal. Of course, the effort can't stop there; domestic violence is a serious deterrent to the general health of our population and is an extremely costly deterrent because of the long-term impact on health-care resources and the many other aspects of parenting and the quality of family life.

Did we make a difference? What is the difference that physicians can make? As the CMS-sponsored campaign has said to the victims: ***"Don't Suffer In Silence! Talk to Your Health Care Provider About Abuse. Help is Available"*** However, there is a condition attached to that, and one that the Colorado Medical Society has taken seriously: the physician must be informed and fully aware of the aspects of domestic violence, i.e., what the patient's physical and mental conditions might be that would indicate that domestic violence possibly had occurred.

We have undertaken this responsibility through our campaign, which involved the efforts of many professional caregivers, psychologists, social workers, researchers, public servants in the domestic courts, social service and welfare departments, and a great deal of CMS staff effort. The Colorado Medical Society Alliance developed an extensive public education program early in 1997 as well.

So, in summary, what have we done? We have assembled all of our information from the experts and others involved, and we have created a booklet for physicians, to put all this information in one easy-to-use format. The book is called

"Make A Difference?"

You can, and we want to help you. The thrust of this campaign has not been to heap more responsibility on the physician's shoulders; our purpose has been to provide your patients with more confidence in your abilities and treatment skills as well as the patient's need to know they can confide in you, ***their advocate.*** We also want to help you be aware of the many clues which would indicate any degree of violence, without putting you in the difficult position of being accused of being insensitive to the patient's needs.

To receive a copy of this little booklet, just send me a letter or postcard saying you want the booklet, ***Making A Difference"*** , and include your name and address. Sorry, we cannot do it by telephone or e-mail... we have to do it by the postal service, and you'll have to send us the request.

There are many other resources available to help you in the campaign to reduce domestic violence and encourage your patients to talk with you on the subject. The booklet includes an up-to-date list of these resources.

Your CMS Alliance is also still actively involved in this campaign as well, so just mention it to your spouse whom, we hope, is a member of the Alliance, or any person involved with the Alliance. They'll be delighted to help you in being as effective as possible in this important advocacy role. If you wish, just call Mrs. Stella Shanks, President, CMSA, at (303) 779-5455, and leave a message that you want the Alliance to help your office in this matter.

Challenge and Opportunity!

Here's the challenge: **Make a difference!** Here's the opportunity: **Let your patients know** that you are their advocate in all matters of their health; this campaign is one of the most effective methods to be found .

RAPE ASSISTANCE AND AWARENESS PROGRAM
P.O. Box 18951
Denver, CO 80218-0951
(303) 329-9922 Hotline: 322-RAPE
TDD: 329-0023 Español: 329-0031
Fax: (303) 329-9964

November 18, 1997

Colorado Medical Society
7800 E Dorado Pl.
Englewood, CO 80111

Dear Colorado Medical Society:

On behalf of the Rape Assistance and Awareness Program, we would like to thank you for your participation in our 1997 Annual Luncheon on October 28. We were thrilled to raise nearly $40,000 to support our services. Your $800.00 *($630.00 is tax deductible)* donation contributed to this success. The dollars raised will directly support our 24-Hour Crisis Hotline, counseling services for victims of sexual assault, and our abuse prevention programs.

We were touched by the sharing of Sheldon Kennedy's story and his ability to discuss how his victimization as a teen has dramatically affected his life. We applaud his efforts and the efforts of all of the victims of sexual assault who we watch deal with their experiences and move forward to become survivors.

Again, thank you for helping us reach our mission to assist victims of sexual violence and educate the public about sexual violence and how to prevent it. All of us at RAAP recognize that there are many organizations which ask for your time and your financial support and we are grateful that you choose to share your resources with us.

Sincerely,

Karmen Carter

Karmen Carter
Executive Director

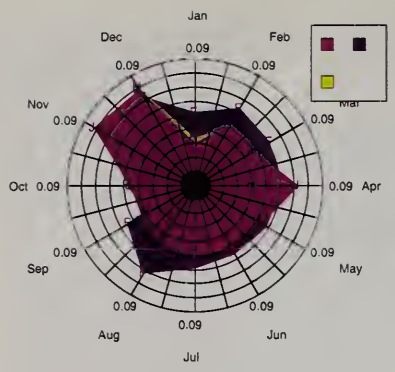
Thanks!

Barbara Yondorf

Barbara Yondorf
Chair, Board of Directors

The CMS support was great. Thanks

P.S.. As a Corporate Sponsor, your feedback is certainly welcome and appreciated. We hope you felt that your sponsorship was valuable. In 1998, we will be celebrating our 15th Anniversary and hope that you will include us in your budgeting plan for next year!



Outcomes Studies



by Howard Shapiro, Ph.D.
Chief, Division of Biostatistics, HealthONE

Validity and interpretation: a statistician analyzes outcomes

"Outcomes studies appear to be of two major types."

The term "outcomes research" has been defined in many ways. Burnside provides a general review of the history of health care outcomes research.[1] In this article, the basic definition I will work from is one put forth by the Agency for Health Care Policy and Research (AHCPR) for its Medical Treatment Effectiveness Research program: *"An examination of the clinical, functional and psychological results of a therapeutic intervention as well as the patient's perception of the outcome of treatment and its effect on quality of life."*

Traditional outcomes have included such indicators as mortality, morbidity, other clinical measures (e.g. blood chemistry, radiology, pulmonary function, etc.), complications and economic factors. Outcomes research adds to those the patient-centered outcomes such as functional status, quality of life, well-being and satisfaction.

In general, validity and interpretation are part of the critical evaluation of clinical studies. Over the past two decades, there have been several series of papers written to assist the practicing physician in such evaluations.[2-3] Also, Yancey discusses how to review clinical research reports with a focus on evaluating their statistical quality.[4]

Validity

When one questions whether a study is valid, specific constructs need to be clearly defined. From a statistical point of view, validity concerns the process by which the data were collected and the extent to which the data are without error. Validity is compromised by such issues as bias, inaccurate databases, and incompatible data systems when data are joined from various sources. An example of the latter in a multinational prostate surgery outcomes study is discussed in a 1994 *Science* article.[5]

Bias can occur from events such as not having enough information about the natural history of untreated conditions (e.g. not knowing whether a response may be due to something other than the treatment) and non-randomization of treatment or patient allocation. Randomization is considered necessary, although maybe not sufficient, to provide the best chance of evenly distributing factors (some of which may be unknown) that may influence response to treatment. When treatment choice is determined by the physician, there may be unconscious prejudices exerted. For example, attributes such as age, gender and severity of condition may influence a physician's decision to choose a particular treatment.

One aspect of the accuracy of data relates to the process by which the data were collected. If patient surveys were used, one would question whether or how well the survey tools were evaluated using generally agreed upon psychometric measures. These include such concepts as test-retest reliability, face validity, construct validity and discriminant validity. With regard to survey tools of general patient functional status, the SF-36 (Medical Outcomes Trust) and the HSQ 2.0 (Health Outcomes Institute) have undergone extensive testing.

One additional influence that

straddles validity and interpretation is adjustment for group comparisons. Most common are adjustments for age, gender, ethnicity, site and severity. A study that would appear to reasonably benefit from severity adjustment, for example, would not be completely valid without such adjustment. After adjustment, one needs to correctly interpret the result.

Interpretation

Common concepts of critical review include investigating the characteristics of the study population, the magnitude of any clinical difference and its clinical relevance, statistical significance, and power. Other areas to scrutinize include the following;

1. Were validated tools used?
2. Were survey questions available for review?
3. What type of statistical adjustment, if any, was performed?
4. Was the study objective addressed?

Outcomes studies appear to be of two major types: descriptive and CQI (continuous quality improvement). For descriptive studies, measures of patient-centered outcomes are summarized. For example, results for average HSQ functional dimensions over time are shown in Figure 1 for a Total Knee Replacement study. One sees relatively large improvements from three to six months after surgery in physical and emotional sectors. The question is how to find value in these results for the improvement of patient care. For CQI studies, one may want to ask questions such as (a) are areas of improvement identified, (b) what specific improvement initiatives result from the study, (c) is there any link to financial performance.

For studies that look at change over time, other factors need to be assessed before a conclusion is drawn as to any relationships found. These may include (a) improved medical technology, (b) better-trained medical personnel, (c) changing health care providers, (d) improved clinical pathways, and (e) new medications.

Finally, to generalize the results of a particular study, one needs to assess the sample characteristics of the patient population under study. For most clinical trials, the patient population consists of a sample of those who happen to use medical care. No information is available for patients with the same condition(s) who do not seek care. Perhaps these patients represent some different set of risk factors not otherwise seen.

Conclusion

Since outcomes studies are still relatively new, there are many unanswered questions. In my view, the following questions are still open:

1. How best to use descriptive results?
2. Does knowledge of patient functional status actually help improve care or efficiency?
3. Can existing outcomes measures be used to effect the same quality improvements?
4. Can the costs of research in the clinical setting be lowered?

Physicians who participate in outcomes studies are needed to help generate hypotheses and subsequent confirmatory studies before the true value of these studies will be apparent.

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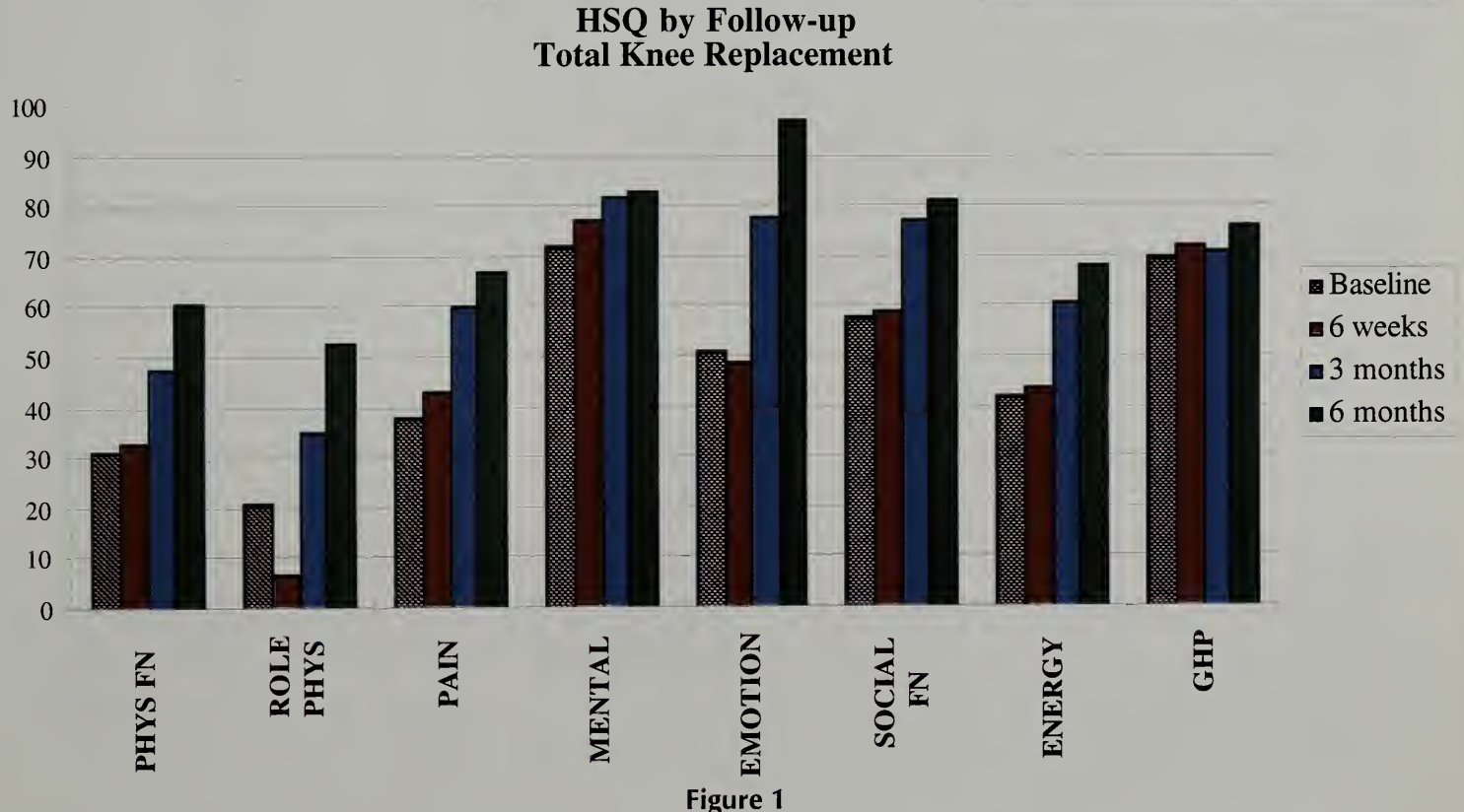


Figure 1

Highlights of the year end coding/payment changes

by Marilyn Rissmiller, CMS Health Care Financing Dept.

"...some of the more common codes are no longer available."

With the new year, Medicare (and most other insurance carriers) will be requiring that billings be submitted using the new and revised codes found in the *1998 ICD-9-CM* and the *CPT '98*. For this reason, it is important that you have the most current edition of these books in your office.

ICD-9 Changes - Effective 1/1/98 for Medicare

Examples of some of the more common codes which are no longer valid include:

438 Late effect of cerebrovascular disease - now requires a more specific fourth or fifth digit;

474.0 Chronic tonsillitis and adenoiditis - now requires a fifth digit and has been split into three codes: 474.00 is chronic tonsillitis, 474.01 is chronic adenoiditis, and 474.02 is chronic tonsillitis and adenoiditis;

780.3 Convulsions - now requires a 5th digit, there are two codes: 780.31 for febrile convulsions and 780.39 for other convulsions;

959.0 Injury, other and unspecified of head, face and neck - now requires a fifth digit and has been split into two codes: 959.01 is for head injury unspecified and 959.09 is for injury to the face and neck;

V76.1 Special screening for malignant neoplasm of the breast - now requires a fifth digit, there are now four codes (**Note:** when billing Medicare for routine mammograms, use V76.12).

CPT '98 Changes - Medicare allows a 90 day grace period

There are numerous changes in the new CPT including the addition of several E & M codes for observation and home care. A notable *deletion* for 1998 is that of the automated panel series, codes 80002 through 80019. Additions and revisions have been made to the Organ or Disease Oriented Panels (80049-80092). These are to be used in place of codes 80002-80019, if appropriate. All of the individual tests listed under the panel code must be performed in order to use that code. If not, the individual CPT codes for each test should be reported. If a "customized" panel includes other tests in addition to those defined in the CPT Panel, the additional tests are reported separately under the individual CPT codes.

Medicare Payment Changes

Beginning with dates of service 1/1/98 and after, there will be one conversion factor for all medical and surgical services (instead of three). That conversion factor is $36.6873. This represents an increase for medical services but a decrease for surgery which had been at $40.9603. The anesthesia conversion factor is $16.8762.

The resource-based practice expense values will be phased in over a four-year period. However, as of 1/1/98 the practice expense portion of some values will be reduced, and the corresponding savings redistributed to office visits. This reduction will apply to those services which are not performed in an office setting at least 75% of the time, and where the practice expense value exceeds the work value by more than 110% (this will affect about 700 codes).

This year's Medicare participation information includes a clarification from HCFA concerning the use of private contracts for Medicare beneficiaries.

The next issue of *Colorado Medicine* will include a coding insert with more detailed information on all of the changes. In the interim, if you have any quesitons, you may contact Marilyn Rissmiller at (303) 779-5455 or 1-800-654-5653, ext. 2428.

PROJECT C.U.R.E.



"Saving lives through medical surplus"

To donate supplies or for more information on Project CURE please call: (303) 727-9414.

Project CURE is a nonprofit corporation that collects and distributes donated medical supplies and equipment to underdeveloped countries. Donations of supplies or equipment are often tax deductible.

Caring for Colorado's Underserved

The Colorado Medical Society is planning the second annual conference ***Caring for Colorado's Underserved.*** The forum is scheduled for:

Friday, March 13, 1998
from 8 a.m. until 5 p.m.
at the Denver Marriott Southeast

This dynamic and interactive conference will update attendees on what has happened since last year's conference and current opportunities for change, financing, policy, and sharing of information related to providing care for this population.

The day will start with a provocative and spirited key note address delivered by Reed Tuckson, MD, AMA group Vice President for Professional Standards and former Commissioner of Public Health for Washington, D.C.

Per the suggestions of last year's participants, during this year's conference we will hold a poster session on successful community models for provision of care to the medically underserved. We encourage you to participate.

We will also again sponsor community service awards for people who have made outstanding contributions in the provision of care to the medically underserved. Nominations will be accepted in the following three categories:

1) physician
2) non-physician provider, and
3) lay person.

Nomination forms will be included in the registration mailing.

Registration information for the conference will be available in January. Put the date on your calendar and watch for more information.

Please call Ellen Stein at CMS (1-800-654-5653 or 303-930-0414) if you have any questions.

COMPAC

An upcoming legislative session, campaign finance reform, impending term limits and as always more legislative changes, how can you keep track of them all? More importantly, how can you protect the interests and maintain the strength and status of organized medicine at the capitol? The answer is COMPAC. Join COMPAC today! Call the CMS Government Relations Department for details at 779-5455 or 1-800-654-5653.

Careful Antibiotic Use in Colorado

by Steven Lowenstein, MD, MPH,
Chief Medical Officer, CDPHE
Kenneth Gershman, MD, MPH,
Medical Epidemiologist, CDPHE

Part I – Background

"...experts now are making baleful predictions of a new 'post-antibiotic era.'"

This month Colorado Medicine *starts a three part series on the use of antibiotics in Colorado. Experts from the Colorado Department of Public Health and Environment (CDPHE) will discuss why the use of these drugs has become an issue, analyze the risks and reasons of overuse, and provide practice tips for careful use of antibiotics.*

It would be hard to imagine medical practice without antibiotics. For more than fifty years, antibiotics have been administered to patients to cure diseases, make surgery safer, reduce suffering, prolong life and protect communities from epidemics. Antibiotics are so effective that in the late 1960's U.S. Surgeon General William Stewart announced that we could "close the book on infectious diseases". In *The Medusa and the Snail* Lewis Thomas wrote, "By and large, infection has become a relatively minor threat to life, as we have civilized ourselves and installed plumbing, and even less a threat now that we have antibiotics".[1]

Indeed, we have antibiotics. The Physicians' Desk Reference lists more than 300 antibiotics. In 1992, an estimated 110 million antibiotic prescriptions were written for outpatients alone.[2] But the problem we now face is that essential antibiotics, including penicillins, cephalosporins, aminoglycosides and macrolides, are no longer uniformly effective. Multi-drug resistant tuberculosis is a serious problem in Colorado and throughout the nation. Two isolates of staphylococcus have been found to carry resistance to all currently available antibiotics, including partial resistance to vancomycin. In 1995 Denver public health officials reported a case of *Neisseria gonorrhea* that was resistant to fluoroquinolones. In hospitals and nursing homes, aminoglycoside-resistant gram negative infections and vancomycin-resistant strains of enterococci continue to cause serious illnesses.[3]

Antibiotic resistance in hospitals and intensive care units has been recognized almost since the discovery of antibiotics.[4] Until recently, primary care and outpatient-based physicians have not had reason to worry. In recent years, however, the emergence of drug-resistant *Streptococcus pneumoniae* (SP) has been widely reported and has brought this problem home to community practitioners. SP is the leading cause of serious community-acquired infections, including pneumonia, bacteremia and bacterial meningitis. SP is also the leading cause of otitis media (OM) in children; according to recent estimates, SP causes more than 6 million OM cases in the United States each year.[5]

The first strains of penicillin-resistant SP were isolated from patients in the mid-1960's. However, in the United States the proportion of SP strains resistant to penicillin remained close to zero until 1987, according to the Centers for Disease Control and Prevention (CDC) sentinel surveillance system. Then, over the next five years the CDC detected a 60-fold increase in high-level penicillin resistance[6]. By 1992, 1.3 percent of invasive SP isolates were highly resistant penicillin. By 1994, the highly-resistant fraction had increased to 3.5 percent. In Colorado two small studies from the late 1970s and early 1980s found no high-level penicillin resistance among invasive SP isolates in the Denver metropolitan area.[7,8] But by 1994, 4.3 percent of invasive SP isolates from Denver hospitals demonstrated high-level penicillin resistance; 13.9 percent demon-

strated "non-susceptibility" (intermediate plus high-level resistance).[9] In 1996 a statewide hospital surveillance system found that 3.8 percent of invasive SP isolates were highly resistant to, and 15.4 percent were non-susceptible to, penicillin (CDPHE, unpublished data).

One recent study from Kentucky and Tennessee found that 29-33 percent of children visiting health clinics were carriers of penicillin-resistant SP.[10] In several cities across the nation, as many as 25 percent of invasive SP isolates have high or intermediate resistance to penicillin.[11] Often, these strains are also resistant to erythromycin, clarithromycin, trimethoprim-sulfamethoxazole and even second- and third- generation cephalosporins.[6] Treatment failures have been reported in patients with pneumococcal meningitis after treatment with penicillin, chloramphenecol, clarithromycin, ceftriaxone and cefotaxime.[12] Ironically, instead of proclaiming the end of the era of infectious diseases, experts now are making baleful predictions of a new "post-antibiotic era".[13]

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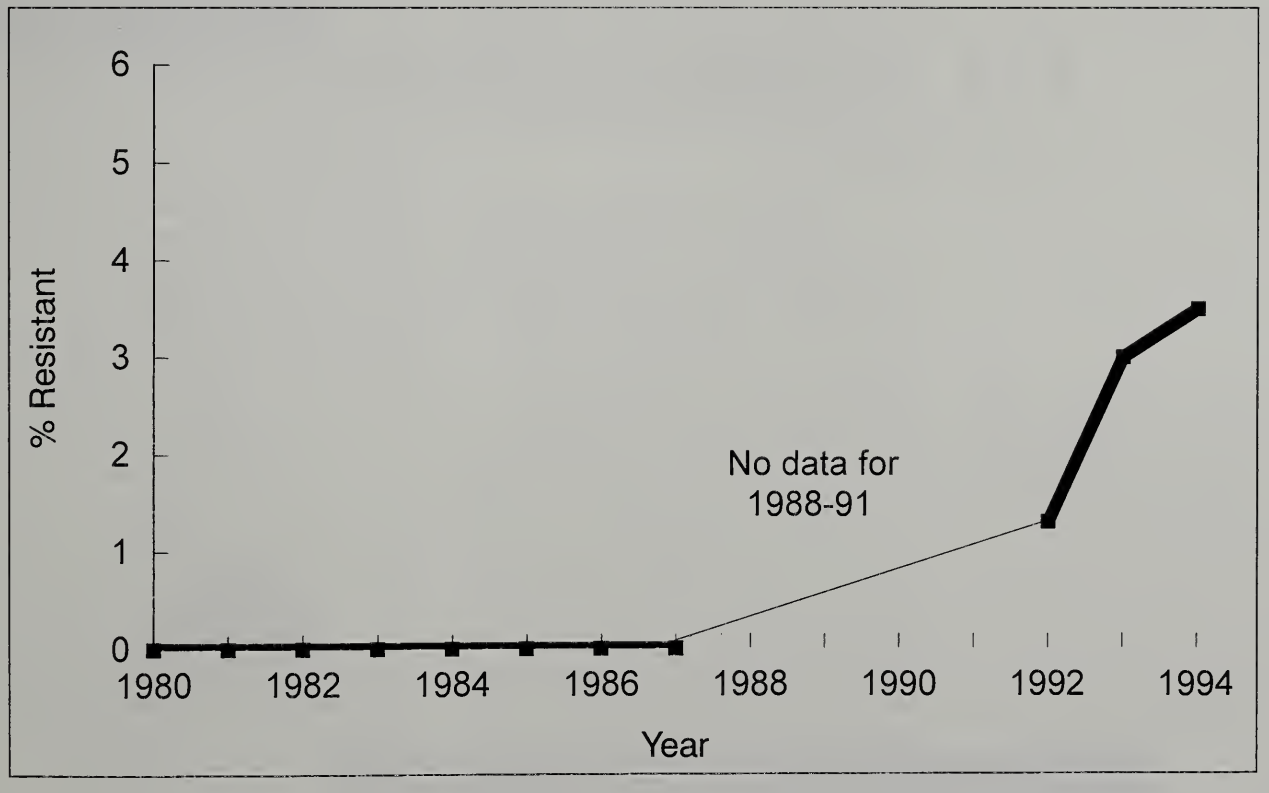


Figure 1:
Rate of high-level penicillin resistance among invasive isolates of S. pneumoniae from national sentinel surveillance, Centers for Disease Control and Prevention (J Infect Dis 1996;174:988)

The Voice of CMS



Lori Bailey, the voice of CMS.

If you have ever called the Colorado Medical Society or Copic Insurance Company you already know Lori Bailey. She is the friendly voice that greets you on the phone as she answers your questions or directs you to someone who can. In today's "rush, rush" society, Lori's familiar, "Colorado Medical Society, how may I direct your call," is the phrase that guarantees you will soon be connected with the person (or voice mail) or receive the information you need.

For over seven years Lori has been the receptionist for CMS and Copic Insurance. During that time she has mastered the whos, whats, wheres and whens of both organizations. Maintaining such an in depth knowledge is no easy task given the fact that both CMS and Copic continue to grow. But Lori's ever-positive outlook makes the job seem easier than it is.

Besides keeping track of everyone in both offices while answering the phone, she maintains the voice mail system, schedules all conference room appointments, greets visitors and performs informal security guard duties to prevent unwanted solicitors or others from interrupting CMS or Copic functions.

Those who have tried to operate a switchboard know what its like to answer phones all day while maintaining a polite, professional attitude. Sometimes the job can get a little hectic. Lori shrugs off the stress with a smile, "For as long as I have been doing this, I have to keep laughing."

The calls come from a wide variety of people. They range from questions by patients and physicians about medical records, CME activities and legislative reform, to what changes are affecting Medicare and where is the best place to go for a sex change.

There is a fine line between listening carefully to a caller's questions and intervening in the conversation because you already know what a caller needs. This talent is Lori's strength. Some would attest that she knows the answers before the questions have even been asked. Yet she does it all very tactfully.

"I'm proud of what I do," she says. "I love the feeling when someone calls and is unsure if we can help them, then I figure out what they need and connect them to the people who can provide answers."

Perhaps the best way to describe Lori's abilities is to make an analogy toward the card game *Concentration*. As the questions come in, Lori knows where all the cards are. She understands what services are available and knows to whom questions should be directed. More importantly, if she doesn't have an answer, she is quick to find one.

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Archives



by John L. Lightburn, MD
Historian, Colorado Medical Society

J. N. Hall, M.D., October 11, 1859 -- December 17, 1939

For some we loved, the loveliest and the best
That from his Vintage rolling Time has prest,
Have drunk their cup a Round or two before,
And one by one crept silently to rest.

OMAR KHAYYAM

One of the benefits of the office of CMS historian is getting to know our early colleagues. My regret is that I know them only superficially and can only guess what they were really like.

John Lightburn

For example, what prompted Josiah Newhall Hall, a brilliant graduate of Harvard Medical School, to leave the comforts of New England after completing his internship at Boston City Hospital and come west to endure the rigors of practice on the barren plains of eastern Colorado? True, his father, Stephen, a farmer near North Chelsea, Massachusetts was also a restless youth with the American dream who had sailed around Cape Horn to California looking for gold in 1849. Three years later he was back on his Massachusetts farm raising a family. In addition, both of his grandfathers were adventurers going off to fight in the War of 1812. Genetic or environmental, Hall was a driven and restless young physician, energetic and eager to be a pioneer and to "follow his bliss" as Joseph Campbell might ay. So, after an arduous trip, he arrived in Denver in 1883. Perhaps he found it too civilized or crowded in Denver since it was only a few months before he moved to the small town of Sterling, population 250. Dr. Hall later wrote that he found himself "isolated as if upon an island in mid-ocean ....My territory was 8000 square miles. The nearest doctor to the west was at Evans, one hundred miles away and east was at North Platte, Nebraska, one-hundred and forty miles away... and I have been six months without seeing another doctor. There was no hospital or nurse...In our first winter, the housekeeper and I ate buffalo meat every day for three months." For the first three years, he was the only physician between Denver and North Platte, Nebraska. But he thrived there, the town grew and he grew with it. He learned to play the double bass and was in the town orchestra; he sang in amateur operas and community chorales. He became involved in politics signing the original town charter and eventually was elected the town mayor. Even more important, he loved to hunt, and he found a hunter's paradise with an abundance of Canadian geese along the Platte river and countless antelope on the high plains. When hunting, he would examine each bullet wound carefully, prompting one of his hunting companions to remark that Dr. Hall had to "conduct a coroner's inquest on every antelope." This was the start of his expertise in gun shot wounds, and four of the eleven medical papers he published while in Sterling dealt with gunshot wounds. Indeed, during his nine years in Sterling, he developed a remarkable skill in observing, examining and understanding the symptoms and signs of the disease process and his reputation as a diagnostician spread throughout the state. His knowledge of gunshot wounds, derived from his hunting experience made him a popular expert witness at murder trials around the state.

In 1875, before Dr. Hall had come west, a widow with two children had come to Sterling from Davis Mills, Mississippi to find a new life. Her fifteen year old daughter, Carrie G. Ayers, became Sterling's first school teacher. Young, bright and pretty (a true southern belle), she and J. N. Hall met, fell in love and were married in 1885. Sterling had turned out to be a truly fortunate choice for the handsome, bearded young man. Mrs. Hall later recalled their first year of marriage living on meat brought home by her husband from his early morning hunting forays.

In 1886, Dr. Hubert Work settled in Fort Morgan, and Dr. Hall was delighted to have a friend and colleague close by. The two of them could now cover the medical needs of Northeast Colorado, mostly on horse back. Eight years later, Dr. Work was to become the 25th president of CMS and thirteen years later, Dr. Hall was elected 30th

president. Although Dr. Hall was well-loved in Sterling, he had higher goals in mind and needed an opportunity for more professional stimulation.

So the Halls left their home in Sterling and moved to Denver in 1892 where he soon was known as the premier internist in the state. His practice flourished as his boundless energy involved him in a wide variety of pursuits. For several years he was Denver City Physician. He taught in two of Denver's three medical schools--Professor of Therapeutics at the University of Colorado and Professor of Medicine at Gross Medical College.

By 1908 his growing practice needed a second physician, and he invited Dr. Tracy R. Love to join him. This professional relationship lasted thirty-one years. Dr. Love did most of the lab work; later a technician was added. In 1959, Dr. Love wrote of his experiences with his mentor: "In the early years of laboratory work, I pumped three to five stomachs every morning of the week. He was extremely rapid in his work, so much so that many remembered, 'It was about 1910 that he spotted a case of hookworm disease, and we not only found the eggs but actually grew some of the worms in the laboratory.' Some years later, we had a severe case of myelogenous leukemia in which I found many nucleated red cells. Many of these showed mitotic cell division. Dr. Hall would come into the laboratory repeatedly when I found a particularly nice specimen under the microscope, until finally in desperation he would say, 'Love, I've got to see a patient in the examining room.' He was extremely rapid in his work... simply bubbling over with energy and enthusiasm. He was so interested in pathology that he was always present when his cases were operated on."

Dr. Hall loved to write and he published 150 papers during his lifetime. The titles of these papers provide an insight into the evolution of his interests. During his first decade in Denver, he wrote 50 papers mostly on heart and lung disease and a few on infections and gunshot wounds. Over the next 20 years, he shifted to gastro-intestinal disease, later adding neurological and renal diseases. His magnum opus came in 1913 with the publication of a two volume text, ***Borderline Disease, A Study of Medical Diagnosis.*** Some called him the "Osler of the West". Sir William Osler was his medical hero and he followed Sir William's three personal ideals:

- to do the days work well
- to follow the Golden Rule
- to cultivate an equanimity to bear success with humility.

Not satisfied with his success, he traveled to Vienna for post-graduate study in 1902 and again in 1907. If you and I had been contemporaries, it is likely that we too might have called him the "Osler of the West".

Devoted as he was to clinical practice and writing papers about it, he also was dedicated to organized medicine. He attended fifty-three consecutive annual meetings of the Colorado Medical Society, a record that is not likely to be surpassed. He was president of CMS from 1899 to 1900 and served two five-year terms on the Judicial Council of the American Medical Association and turned down nomination to the A.M.A. presidency at age 74, saying he was too old. He was on the State Board of Health for 27 years and the State Board of Medical Examiners for six years. He was active in the American Climatological Association, the American Therapeutic Society, the Medico-Legal Society of New York and the Denver Clinical and Pathological Society and the Colorado Historical Society.*

It is hard to believe that he still had time to take his two sons, Sigourney and Oliver, on hunting expeditions in western Colorado. When we became involved in World War I, he served in the Army, 1917 to 1919, as Chief of Medicine at the base hospital at Camp Logan, Texas and later as consultant for nine south-western cantonments. Ironically, his younger son, Oliver, who had just earned an engineering degree from the University of Michigan, enlisted in the Army and died of the Spanish flu in 1918 while his father was deeply involved in caring for hundreds of soldiers dying of the same disease. How tragically painful that must have been for the Halls!

After the war, he continued his practice in the same dedicated fashion until he retired in 1936. He was known for his wonderful stories, and it is appropriate that his last book, published in 1937 was, ***Tales of Pioneer Practice,*** being ***Reminiscences of the Ways and By-ways of the Early Day Medical Fraternity in Colorado.*** In the Epilogue of that book, he wrote "In my *Tales of Pioneer Practice* I have but wandered but haphazardly down memory's lane, touching an incident here and there that seemed at the moment worthwhile the telling. And now, in ending my tales, I have the feeling that, of the many medical men I have known in early day practice and whose names I have neglected to mention, interesting tales could and should be told. To these countless beloved friends I hereby and herein acknowledge my fault. It was of the fallibility of mind--not of the heart."

After three more years of active retirement Dr. Hall died on December 19, 1939 in his eightieth year.

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Broen, Robert K., M.D., "J.N. Hall, Pioneer Physician", *Roundup,* xxxvii:4, July, 1981

Love, Tracy R., M.D. , ***Centennial Doctor, Personal Glimpses of Dr. Josiah Newhall Hall,*** The Library Quarterly, III:1, March, 1959

Editor's Note:
Please see **"RUMINATIONS"** in this edition.

Colorado Medical Society Alliance



by Stella Shanks, President,
Colorado Medical Society Alliance

AMA-ERF

Those of you who know me and know how committed I am to the American Medical Association Education and Research Foundation (AMA-ERF) probably know what I am about to say. You have heard me talk about this subject at the CMS Annual and Interim Meetings. However, the importance of this cause cannot be over emphasized.

Making sure the nation's future physicians receive the training they need to maintain the best health care in the world is the first priority for U.S. medical schools. A close second is finding ways to finance training as spiraling costs and shrinking dollars combine to make needed sources of funding scarce. Helping medical schools achieve those goals is the purpose of the American Medical Association Education and Research Foundation, which has distributed more than $65 million to the nation's medical schools in the past 40 years. A major factor in the success of the AMA-ERF has been the involvement of AMA Alliance members.

In the last 20 years, the Colorado Medical Society Alliance (CMSA) has raised $637,688.20 for the University of Colorado School of Medicine. The Alliance provided you the opportunities to contribute, but the money came from your pockets. We thank you for supporting the Sharing Card project during the holidays, and for purchasing chances on the basket raffle held at your meetings. Money was also contributed in your honor by your spouse, family or friends. All of the money came from the medical families.

Contributions to AMA-ERF are more than just charitable donations. They are a legacy from one generation of medical professionals to the next and an investment in the health of generations to come. As the Alliance continues to embrace the cause in its commitment to excellence in medical education, we support the theme "The Medical Student Today Will Be Your Physician Tomorrow" focusing on our future physicians and the profession of medicine. By investing today, contributors are affecting the quality of medicine tomorrow. Many medical facilities, research projects, grant recipients and resident physicians have benefited because of physician and Alliance member donations and hard work for the AMA-ERF.

Did you know that 100 percent of your contributions goes to the medical school or research project of your choice? This is possible because the money is held in an interest bearing account until the following April, and the interest is what pays for all administrative costs. Each month, the dean of each medical school is informed of the amount designated to the school in the preceding month. Did you know that you can contribute to one of two funds? The first is the Medical School Excellence Fund which gives grant money to medical schools to use as they see fit. The Medical School Assistance Fund provides funds to medical schools for student financial aid.

Thank you for all you have done and continue to do for AMA-ERF. Holiday time is here again. Please continue your generosity to this great need. Your local Alliance probably has a fund raiser allocated to AMA-ERF during the year. If not, you may forward your contribution to the state chair, using the form below.

Yes, I want to contribute to the future of medicine! Here is my donation to AMA-ERF.

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Fund to receive contribution: Excellence Fund ❑ Student Assistance Fund ❑

Mail this completed form with your check payable to AMA-ERF to: Karen Smith, 96 Purdue St., Pueblo, CO 81005.

Colorado HMO enrollment up, profits down

HMO enrollment is up sharply in Colorado, but their premium revenues are down and their profits have disappeared. Hospitals, on the other hand, are enjoying higher profits as they gradually configure themselves into a series of systems. Employers continue to enjoy a buyers' market while physicians try different configurations for organizing themselves and dealing with managed care.

These and other findings are contained in *Colorado Managed Care Review 1997*, Allan Baumgarten's fourth annual report analyzing key trends and issues in the Colorado health care market. The report combines a competitive analysis of HMOs and hospitals with an assessment of how initiatives by purchasers and others are influencing the direction of the market.

Among the report's findings:

- HMO enrollment in Colorado grew 16.5 percent in the past 12 month period and reached 1,244,000 on June 30, 1997.
- Average premium revenue for commercial enrollees fell 3.4 percent in 1996 and profit margins declined to only 1.5 percent of revenues.
- Government programs will have significant impact on health plans and hospitals. Strong growth in HMO Medicare Risk plans will continue to spur increased HMO enrollment, while increasing the pressure on hospitals to achieve operating efficiencies.
- Hospitals in the Denver metro area had average profits of 7.2 percent in 1996, up from 6.0 percent in 1995.

Copies of the report are available for $75. Please call (612) 925-9121 for details.

FTC settles lawsuit with Mesa County Doctors

The Federal Trade Commission (FTC) reached an out-of-court settlement to its lawsuit against the Mesa County Physicians Independent Practice Association last month. Details of the agreement have not been disclosed, but the settlement by the FTC is a victory for Mesa County physicians and organized medicine alike.

At issue was the FTC's allegation that Mesa County physicians (90 percent of whom belong to the IPA) fixed prices and unfairly limited competition. Investigations by the FTC began more than a year and a half ago. Throughout it all the IPA denied any wrongdoing. The physician group did agree to change the way it reviewed and entered into contracts. It also disbanded its contract review committee. Despite these efforts the FTC stubbornly held onto its belief that the group had to be broken up because of antirust laws. The IPA refused to comply, and soon afterward FTC lawyers filed suit.

The settlement is not final, however insiders expect that the FTC commissioner will approve the details. All told the suit drew national attention, spotlighting some of the issues that most rural physicians face. Organized medicine rallied around the cause, with significant financial and legal help from the American Medical Association. The suit cost the IPA over $500,000 in legal and consultant fees. The AMA has helped pay some of that cost, the rest should be paid by the IPA's insurance policy.

Family physicians to celebrate 50th Anniversary

The Colorado Academy of Family Physicians (CAFP) will celebrate its 50th Anniversary on October 3, 1998. The black tie event will present awards to outstanding Colorado family physicians. The gala will also help raise funds for CAFP and its Foundation which support the education of family physicians and assist Colorado's family physicians in providing quality patient care.

Tickets to the CAFP 50th Anniversary Celebration are now available for purchase. Please call Randi Morris for more information at (303) 696-6655 or 800-468-8615.

Among others the gala is sponsored by the American Academy of Family Physicians, Colorado Medical Society, Colorado Access, Columbia HealthOne, Copic, Health Network of Colorado Springs, PacifiCare, Prudential and University of Colorado Foundation.

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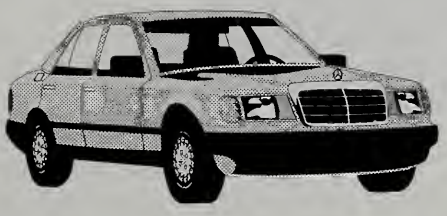
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Colorado Medical Society

RUMINATIONS

(**def:** chewing again what has been chewed slightly and swallowed; to **REFLECT**)

*by **Bill Pierson**, Managing Editor*

***NOTE:** Be sure to read **"ARCHIVES"** by Dr. John Lightburn . . . in this issue.*



During college in the '40s I worked for radio station KFKA in Greeley, Colorado. The owner was Mr. H. E. Green, publisher of the *"Record Stockman"*. My schedule necessitated my going to class in Denver Monday through Friday and then hightailing it to Greeley to work a full-time shift over the weekend. Sunday nights I streaked (that's when the term meant "moved swiftly") back to Denver to get to class Monday at 8:00 a.m. (During that time I created a small part-time business in which I went to work for the father of U. S. Secretary of State Madeleine Albright, but that's a story for another time.)

One Friday evening on my way to Greeley, my 1938 Plymouth threw a piston rod in Platteville, and I had to start riding the Motorway bus. This bus route traveled the old Brighton Boulevard out through the Denver Union Stock Yards.

I can remember passing York Street and "Brighton" (as we called it) just off the entrance to Riverside Cemetery, and often seeing this piece of chiseled granite. It was obviously a marker of some sort and it sat right there on the funny-shaped corner out in the middle of nowhere.

Strange things happen: this month I got a phone call from **Beckley, West Virginia.** What got my attention first was that I have never received a phone call from W.Va. since I left there 61 years ago. The second thing was that **the call was from Dr. Ed Tennant** of **Sterling, Colorado**, doing locum tenens in Beckley covering for a physician's illness.

Dr. Tennant has been a fan of the National Western Stock Show & Rodeo for many years. Since he was out of state he wanted me to see about getting him tickets for the January show. I was happy to try, so my travels took me to the National Western arena on a Saturday. After pursuing the tickets (to no avail/sold out the night he could go), I wondered what was left of the old complex . It's just a skeleton of the past ... empty stock pens; the old "Exchange" building (offices of the *"Record Stockman"*, livestock dealers, auctioneers), some skeletal remains of the big packing houses (Armour, Cudahy, etc.). It is eerie!

I drive around... looking. Then I think of the weekend bus rides I had for most of my college life so I drive out Brighton Boulevard. I'm just moseying along (there is no other traffic out there), and suddenly, there it is... that granite marker sitting on that dusty, isolated corner. I stop and read it, and as I do I recalled reading it a long time ago.

Ironically, it was one of Colorado's pioneer physicians, Josiah N. Hall, MD - **early of Sterling, CO** - who was chiefly responsible for this marker, ***"Commemorating the Route of the Platte River Trail"***. Dr. Hall gave this marker to Coloradans in memory of his wife, and it was dedicated, according to the Denver Post, "On the sunny Saturday afternoon, September 23rd, 1933..."

Stranger still, December's **"ARCHIVES"** by Dr. John Lightburn, is about Josiah Hall. Don't miss it!



After the long and circuitous route (thanks to a dear friend who was somehow moved to call from W.Va. about tickets to the National Western), I was caused to examine some of my own history, thus seeing the monument again. The circle is completed.

When you're loose in Denver, I urge you to drive by Brighton Boulevard and York and to visit Riverside Cemetery - an area rich in Colorado history.

5397--

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